

AN EXPLORATION OF THERAPEUTIC WORK WITH
UNACCOMPANIED REFUGEE YOUNG PEOPLE

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Abstract

A review of existing literature indicates a lack of research regarding mental health service provision and therapeutic work with unaccompanied refugee young people, despite studies suggesting numerous concerns and challenges. Furthermore, reviews of mental health service provision for this group point to the need for more research in this area to inform and improve practice. Given the paucity of research, the present study aimed to explore therapists' accounts of therapeutic work with unaccompanied refugee young people. A social constructionist grounded theory approach was used to analyse data from nine semi-structured interviews carried out with therapists working with these children. Theoretical concepts were constructed to conceptualise a process of 'responding to children's needs' by balancing 'holding onto' and 'putting aside' models of therapy. These were interwoven with the following three categories: 'meeting children where they are', 'balancing boundaries' and 'managing positioning' in relation to unaccompanied children and the socio-political context of the therapeutic work.

The study drew on the analysis of the data to construct a grounded theory of processes occurring in participants' accounts of therapeutic work with unaccompanied children. Findings of the research suggest therapeutic work with this group presents challenges to therapists' roles, to available models of therapy and to managing complex emotional responses in relation to the socio-political context. Participants' responses to these challenges were conceptualised in an ongoing process of 'searching for a middle ground' within the complexities of the work. The findings are discussed with regard to existing literature about working with unaccompanied children and groups who share similar characteristics. Recommendations are made regarding professional practice, training needs and further research.

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Chapter 1: Introduction

This chapter aims to contextualise the present research and establish the current state of knowledge regarding therapeutic work with young people who arrive in the UK unaccompanied to seek asylum. The chapter begins by providing a definition of this group in order to outline the context of the therapeutic work. It then reviews literature pertinent to therapeutic work with these children. Including: therapy with accompanied refugee young people; social work with unaccompanied refugee young people as a significant area of research regarding practice with this group; and existing research regarding therapeutic work with these children. The chapter ends by discussing the rationale for the present research, presenting the research questions guiding the study and the criteria for evaluating the grounded theory.

Unaccompanied refugee young people are referred to using a number of different terms in the literature. These terms include: 'unaccompanied' or 'separated'; 'asylum seeking' or 'refugee'; and 'children', 'adolescents', 'young people' or 'minors'. To identify relevant work for inclusion in the review, combinations of these terms were used systematically to identify research related to this group of children. These search terms were used in conjunction with the key-words: 'psychotherapy', 'therapy', 'psychology', 'clinical psychology', 'counselling' and 'counseling' (United States spelling) to locate research about working therapeutically with this group. Literature searches were conducted using the following databases: EBSCO (including psycINFO, psycARTICLES, Academic Search Complete and CINAHL), PEP-WEB and Science Direct for 'ANY' text associated with the search terms. After identifying literature, full text electronic journals and books were sourced where possible. In reviewing sourced literature, additional relevant literature was also identified from reference lists.

1.1 Unaccompanied refugee young people

This section introduces definitions of this group and the legal context of seeking asylum in the United Kingdom (UK). Research regarding psychological and social

experiences shared by many of these children is described. Following this, literature pertaining to unaccompanied children's wellbeing and reviews of the provision of mental health services for this group is reviewed.

1.1.1 Legal context

Unaccompanied refugee young people are defined by the United Nations High Commissioner for Refugees (UNHCR, 1994, p.121) as: 'those who are separated from both parents and are not being cared for by an adult who, by law or custom, has responsibility to do so'. Definitions of this group share three key components that describe their status in terms of: entering a country seeking asylum; their separation from parents or customary care givers; and, as younger than 18 years of age (Derluyn, Broekaert & Schuyten, 2008; Kohli & Mitchell, 2007).

Article 1A(2) of the Refugee Convention (1951, amended in 1967) is the central criterion used to judge whether applications are assigned refugee status and therefore leave to remain in the UK. The article defines a refugee as 'a person who is outside of his/her country of nationality' and 'has a well-founded fear of being persecuted for reasons of race, religion, nationality, membership or a particular social group or political opinion' (UNHCR, 2007).

Article 22 of the United Nations Convention on the Rights of the Child (UNCRC, 1991) states that host countries have a responsibility to afford refugee children 'the same protection as any other child permanently or temporarily deprived of his or her family environment'. Upon arrival in the UK, only a small minority of children¹ are likely to be granted refugee status and indefinite leave to remain (Chase, Knight & Statham, 2008). The vast majority receive discretionary leave to remain until they turn 18 years of age. Children must then apply for asylum in order to remain in the UK after their 18th birthday (Thomas, Thomas, Nafees & Bhugra, 2004).

¹ For the purposes of this report, where the term 'children' is used it should be taken to mean 'unaccompanied refugee young people' unless stated otherwise.

1.1.2 Psychosocial experiences

Recent statistics regarding the nationalities of unaccompanied children in the UK indicate the highest numbers fled from Afghanistan, Iran, Iraq, Somalia and Eritrea (Home Office, 2011). Studies of children's psychosocial experiences tend to divide their stories into three elements: pre-flight experiences in their countries of origin; experiences of fleeing their homelands and journeying to exile; and, finally, experiences of arriving and settling in countries of asylum (Rutter, 2001; Fazel & Stein, 2002). Research into children's pre-flight experiences has increased awareness in western academia of the range of distressing events they are likely to be exposed to in their countries of origin (e.g. Hopkins & Hill, 2008, Thomas et al., 2004). Children's journeys into exile are often prolonged and dangerous (Richman, 1998). Refugee people are often forced to use illegal means to access Europe; this is the case for the majority of children travelling to the UK (Morrison & Crosland, 2001).

Although children may hope to arrive in a place of safety, Simmonds (2004, p.73) describes their experience as 'fleeing from danger to danger to danger'. They may have unwelcoming and distressing experiences of arriving into countries of asylum (Crawley, 2007; De Anstiss, Ziaian, Procter, Warland & Baghurst, 2009; Halvorsen, 2002; Reijneveld, de Boer, Bean & Korfer, 2005). Concern regarding perceived 'exploitation' and 'draining' of services has created a 'culture of disbelief', which may result in children feeling criminalised by asylum systems (Bhabha & Finch, 2006; Hintjens, 2006; Kohli, 2006). Children encounter an accumulation of losses over the course of their experiences: externally, of their family, home, culture, and way of life; and, internally, of their sense of agency and safety (Chase, 2010; Groark, Sclare & Raval, 2010; Hek, 2005; Vitus, 2010). For many, their living situations in the UK may be lonely and isolated without their families or familiar social networks (Lay, Papadopoulos & Gebrehiwot, 2007; Stevens, 2006). Studies of children's experiences of living in the UK show uncertainty about the future is an overriding concern, with regard to their asylum application and fears of detention, dispersal or deportation (Fekete, 2007; Nandy, 2007; Wade, Mitchell & Baylis, 2005).

1.1.3 Research on unaccompanied young people's wellbeing

Within well-being research there is a split between focusing on refugee children's psychological vulnerability, in contrast to their resilience. This is illustrated by: Hodes' (1998) paper, 'Refugee children: May need a lot of psychiatric help'; and, Timimi's (1998) response, 'Refugee families have psychological strengths'. The polarised vulnerability/resilience debate is evident in research about the well-being of unaccompanied refugee children, indicating overtones of individualism and protectionist views of childhood peculiar to western cultures. The majority of research focuses on children's 'vulnerability' to mental health problems (Bean, Derluyn, Eurelings-Bontekoe, Broekaert & Spinhoven, 2007; Hodes, Jagdev, Chandra & Cunliffe, 2008; Huemer, Karnick, Voelkl-Kernstock, Granditsch, Dervic et al., 2009; Vaage, Garlov, Hauff & Thomsen, 2007; Wallin & Ahlstrom, 2005; Wiese & Burhorst, 2007). The most common psychiatric diagnoses discussed in this research are post-traumatic stress disorder (PTSD), somatic conditions, depression, and anxiety-related disorders.

Blackwell and Melzak (2000) identify a number of experiences that are considered to cause acute stress and distress to all children; including violence, persecution, injustice, loss and bereavement, sudden change, displacement, poverty and deprivation, the absence of supportive relationships, and, uncertainty about the future. Unaccompanied children live with many of these experiences and are therefore thought to experience considerable emotional distress (Groark et al., 2010). We are reminded, however, that 'adversity does not automatically lead to mental health problems' (Groark et al., 2010, p.422). Literature emphasising children's resilience highlights their ability to adapt under extreme circumstances and cope with distressing experiences (Abunimah & Blower, 2010; McCarthy & Marks, 2010). Children have been found to use a number of coping strategies, including religion, education, and suppressing emotions by seeking distractions (Cowley, 2009; Luster, Qin, Bates, Rana & Lee, 2010; Raghallaigh, 2011; Raghallaigh & Gilligan, 2009).

Vulnerability-focused research has been criticised for constructing 'tragic identities' and downplaying children's strengths (Kohli & Mitchell, 2007, p.xiv). On the other hand, Evans (2008, p.33) warns against polarised perceptions of refugee children as

‘inherently resilient’. Instead, Hopkins and Hill (2010) consider experiences of being unaccompanied to increase both children’s psychological vulnerability and resilience. Derluyn and Broekaert (2007) conclude that, in order to meet their emotional needs, unaccompanied children require mental health services to be more easily accessible and to provide more extensive offers of mental health care. In light of this recommendation, the following section summarises reviews of western mental health service provision for this group.

1.1.4 Reviews of mental health services for unaccompanied young people

Concerns have been raised about service provision in multiple areas of unaccompanied children’s lives; including accommodation, education, social activities, and legal support for asylum applications. Inadequate responses of services in each of these areas have been found to impact considerably on children’s levels of distress and mental health (Atlas, 2006; Ayotte & Williamson, 2001; Crawley, 2004; Hodes et al., 2008; Kralj & Goldberg, 2005; Stone, 2000).

Mental health services available to unaccompanied children in the UK are made up of Child and Adolescent Mental Health Services (CAMHS) within the National Health Service (NHS) and specialist non-governmental mental health services developed specifically to provide support and therapy for refugee people, such as the Medical Foundation for the Victims of Torture (Free, 2003). Despite the range of mental health services available, unaccompanied children’s mental health needs have been found to be inadequately responded to by western mental health services (Ayotte & Williamson, 2001; Bean, Eurelings-Bontekoe, Mooijaart & Spinhoven, 2006; Farrah, 2008; Friedman & Klein, 2008; Nadeau, Hannibal, Sirkin & Nightingale, 1997). Unaccompanied children may feel reluctant to seek help from western mental health services due to a failure to accommodate their cultural needs (Bemak & Timm, 1994; Thomas et al., 2004). Consequently, these children have been found to not attend appointments and prematurely end therapy (Bean, 2006; Michelson & Sclare, 2009).

The United Nations’ UNICEF UK report ‘Levelling the Playing Field’ indicated ‘significant concerns’ regarding the appropriateness of mental health service

provision for unaccompanied children (Brownlees & Finch, 2010). Concerns included a lack of culturally appropriate services and a lack of appropriately skilled professionals with experience of working with this group. An earlier report, 'Cold Comfort', by Save the Children also found unaccompanied children experience difficulties accessing mental health services (Stanley, 2001). Brownlees and Finch (2010) suggested some mental health professionals were reluctant to begin therapeutic work due to uncertainty surrounding children's legal status. Other professionals refused to treat the children at all, arguing the practical circumstances surrounding their lives would inhibit any effect of therapy (Bean, 2006). Although unaccompanied children have some of the same needs as other children, researchers suggest they also require adaptations to service provision to address their particular needs and circumstances (Kidane, 2001; Simmonds & Merredew, 2010).

The review 'Seeking Asylum Alone' highlighted the absence of a national strategy to ensure good practice in mental health services for unaccompanied children (Bhabha & Finch, 2006). This was found to lead to pockets of good practice and a 'postcode lottery'; meaning some children are referred for 'high quality' therapeutic work, such as at the Tavistock Centre or Medical Foundation, and others receive nothing (Bhabha & Finch, 2006, p.85). Research suggests unaccompanied children can benefit from the right type of therapeutic intervention and long-term therapeutic relationships can be essential for some children's mental health (Chase et al., 2008). The lack of research about working with the mental health needs of this group, however, means there is little literature to shape appropriate services (Bemak & Greenberg, 1994; Chase et al., 2008; Ehntholt & Yule, 2006). There is therefore a need to develop more expertise in therapeutic work with unaccompanied children (Stone, 2000).

1.1.5 Summary

Research suggests unaccompanied children are likely to encounter a range of distressing experiences, which may increase both their psychological vulnerability and resilience. Reviews indicate there is a need to improve the accessibility and

appropriateness of practices within mental health services for this group, including therapy. There is little research about therapeutic work with unaccompanied children; the following section therefore explores existing research regarding therapeutic work with refugee children who are accompanied in exile by their families.

1.2 Therapeutic work with refugee children accompanied in exile

The dearth of research regarding therapeutic work is not restricted to unaccompanied children. Existing studies argue that there is insufficient research regarding therapy with refugee people of all ages, and that it is unclear which aspects of interventions used by western-trained therapists are beneficial for this population (Maslin & Shaw, 2006; Tempny, 2009). In her study of work with refugee children, Yohani (2010) remarks on the paucity of literature to better equip mental health professionals in their practice. A review of existing literature about therapeutic work with accompanied refugee children highlighted challenges for therapists ensuring the accessibility and appropriateness of therapy, as well as managing emotional responses to children's experiences. The following section outlines these challenges and considers possible applications to therapeutic work with unaccompanied children.

1.2.1 Accessibility of therapy

Hodes (1998, p.793) suggests that a lack of familiarity with western mental health services may mean refugee children and families experience clinic-based services as 'bewildering'; resulting in these services being underused by this group. Much research about therapeutic work with refugee children has focused on providing mental health support in schools (Fazel, Doll & Stein, 2009; German & Ehntholt, 2007; Kia-Keating & Ellis, 2007). O'Shea, Hodes, Down and Bramley (2000) established a school-based mental health service for refugee children offering therapeutic work with children as well as consultations with teachers, educational psychologists, and social workers. This model was found to be a more accessible

and effective way of working with refugee children and their families. Although research has attended to the 'bewildering' nature of western mental health services regarding accessibility, this observation has not been applied to western mental health practices more broadly, including potential confusion as a result of a lack of familiarity with practices within therapeutic work.

1.2.2 Appropriateness of models of therapy

Ehnholt, Smith and Yule (2005) conducted a school-based Cognitive-Behavioural Therapy (CBT) group for 26 refugee children offering psycho-education and coping strategies for PTSD symptoms. The group was found to have somewhat limited effectiveness and post-treatment improvements were not maintained two months later. From her interviews of therapists working with refugee children, Warr (2010) contests the appropriateness of single therapeutic approaches. Instead participants of this study reported integrating several different approaches to respond flexibly to children's needs. Rather than employing CBT techniques only, systemic approaches were recommended to highlight the wider social and political context of therapeutic work.

1.2.3 Managing therapists' emotional responses

Research indicates therapists may experience challenges managing their own emotions within therapeutic work with refugee children (Melzak & Woodcock, 1991). The literature refers to concepts developed in relation to people encountering trauma and stress 'second hand'; such as 'vicarious traumatisation' (McCann & Pearlman, 1990), 'burnout syndrome' (Maslach et al., 1996) and 'compassion fatigue' (Figley, 1995). For example, Yohani (2010, p.871) warns professionals may experience compassion fatigue or burn out as a result of refugee children's 'pain, grief and stories of trauma and loss' as well as feelings of despair regarding limited resources available to meet children's needs.

1.2.4 Summary

Research suggests refugee children may experience mental health services as confusing, and adaptations to service delivery may be necessary to increase accessibility. Studies of therapeutic work raise questions regarding the appropriateness of western therapy, focusing on trauma, and employing single models of therapy for refugee children. The literature also indicates challenges for therapists managing their emotional responses to working with refugee children. It could therefore be inferred that therapeutic work with unaccompanied children may present challenges regarding accessibility, appropriate applications of western models of therapy, and managing therapists' emotions.

1.3 Social and support work with unaccompanied refugee young people

Research about unaccompanied children has tended to remain within disciplinary boundaries and has been criticised for not sharing practice across disciplines (Kohli, 2006). In contrast to therapeutic work, the social work profession has provided a significant research base regarding working with unaccompanied children. Studies of social work, as well as support work, were therefore incorporated into the literature review. The following section outlines research regarding challenges social and support workers may experience with unaccompanied children and considers the relevance of these issues to therapeutic work. Challenges identified in the literature are grouped into three main categories: managing relationships with children; coping with the emotional impact of the work; and, working in the context of the UK asylum system.

1.3.1 Relationship challenges

In response to their awareness of the extent and complexities of unaccompanied children's emotional needs, Free (2003) notes that support workers may feel frightened of engaging with this group for fear of feeling out of their depth. Support workers are encouraged to provide long-term support to children through high and

low periods of their lives (Mels, Derluyn & Broekaert, 2008). Children may only begin to talk about emotional problems once they have developed a relationship with support workers with whom they have regular interactions (Free, 2003). The knowledge that they may be one of the few adults these children know and can talk to may place support workers under further pressure. Social workers emphasise the importance of taking time to develop trusting relationships, rather than 'rushing in' and interrogate children or 'rushing out' and risking breaking 'bonds of attachment' with children already coping with significant losses (Kohli, 2006, p.4). Kohli's (2006,p.5) model of resettlement suggests social workers support children to deal with the 'present first, the future next and the past last' in order to enable them to settle in the UK.

1.3.2 Emotional challenges

Kohli (2011) found social workers may feel disheartened when unaccompanied children are deported from the UK, because it might feel as if their hard work has been undone. The literature indicates that professionals' emotional experiences may mirror children's. They may experience feelings of 'helplessness, impatience, frustration and isolation' (Free, 2003, p.9), or feel as if they are living between hope and despair regarding the uncertainty of asylum applications (Kohli, 2007). Working with this uncertainty may be both intellectually and emotionally exhausting. Social workers have consequently been found to develop a 'tired, seen it all before' cynicism (Kohli, 2007, p.36), which may be suggestive of burnout. Kohli (2006, p.5) observes social workers to manage their work with unaccompanied children in three different ways, as 'humanitarians', 'witnesses' and 'confederates'.

Humanitarians are described as focusing on 'here and now' practicalities of resettling by meeting children's practical needs in their external world. Witnesses focus on children's internal worlds through listening to, containing, and meeting their emotional needs. Confederates focus on supporting children to feel at home in the UK by developing strong attachments, such that children may refer to them in parent-like ways. Witnesses may experience challenges supporting children with distressing emotions and, in response, were found to retreat to humanitarian

positions to create distance and limit their role to practical help. Alternatively, they were also observed to move to confederate roles; blurring boundaries between professional support and friendship to lessen distance and provide additional emotional support (Kohli, 2006). Although not conceptualised as such within the research, these observations indicate professionals may experience challenges maintaining appropriate emotional distance and might alternate between being ‘too close’ to or ‘too far’ from these children (Byng-Hall, 1988).

1.3.3 Contextual challenges

Local Authorities have dual roles as ‘corporate parents’ to unaccompanied children and also as gatekeepers to services. Social workers may consequently experience tensions managing contrasting roles as ‘surrogate parents’ to children as well as controlling resources (Kohli, 2006, p.3). Research suggests concerns regarding limited resources and the culture of disbelief can become dominant in social services, resulting in a hardening of practice and attitudes towards children (Ayotte & Williamson, 2001; Mitchell, 2003). As an alternative, social workers have described taking an ‘agnostic, neutralised’ stance towards children’s claims by suspending their disbelief (Kohli, 2006, p.6). Rather than viewing children negatively in terms of what they are perceived to ‘take’ from society, research highlights the importance of holding positive views of children’s contributions to society (GLA Policy Support Unit, 2004). The literature also indicates potential ethical dilemmas regarding social workers’ roles in supporting children’s resilience to cope with being deported from the UK and their duties to safeguard children, which might sometimes mean protecting them from the asylum system (Newbigging & Thomas, 2011; Thomas & Devaney, 2011).

1.3.4 Summary

Research about social and support work with unaccompanied children highlights a number of issues that may be relevant to therapeutic work with this group. Suggestions of children’s long-term support needs raise questions regarding how

this might fit with shorter-term therapeutic work. Studies indicate potential challenges not only beginning, but also ending therapy work with unaccompanied children. Kohli's (2006) framework of 'present first, the future next and the past last' may have implications for the focus of therapy with unaccompanied children, such as in terms of trauma-focused work. Research suggests possible challenges maintaining appropriate emotional distance in relation to children. The literature also indicates potential ethical dilemmas regarding working in the context of the UK asylum system and supporting children through practices that may be perceived to threaten children's safety.

1.4 Therapeutic work with unaccompanied refugee young people

The National Institute of Clinical Excellence (NICE, 2006) recommend therapeutic work should focus on supporting unaccompanied children to develop a sense of stability in their lives and suggest offering children a course of 8–12 individual sessions of trauma-focused CBT. Given issues raised in relation to focusing on past trauma in work with both accompanied and unaccompanied children as well as suggestions of children's long-term support needs, this recommendation may represent an insufficient response. The following section draws on literature regarding therapeutic work with this group to consider implications for NICE guidelines and explore challenges that may arise in therapy with these children. These challenges have been grouped into a number of sub-sections: the acceptability of therapy for unaccompanied children; questions regarding approaches to therapy with this group; debates around therapists' roles; concerns surrounding western concepts within therapy; issues regarding understandings of therapy in different disciplines; and, finally, difficulties therapists experience responding to emotional distress within therapeutic work with these children.

1.4.1 Acceptability of therapy

Accessibility is raised as an issue in reviews of mental health services for unaccompanied children, suggesting therapists may encounter challenges ensuring

therapy is accessible for this group. However, beyond confusion and a lack of familiarity, research suggests further factors that may also influence the acceptability of mental health services. Children may not trust professionals in the UK and, as a result of their experiences, may confuse enquiry with interrogation and respond to questions with silence or suspicion (Kohli & Mather, 2003). Summerfield (1995) also notes that some people who participate in torture have been doctors and health professionals in children's countries of origin. This is likely to impact considerably on their 'relationship to help' (Reder & Fredman, 1996). A heightened stigma of mental health problems in non-western cultures and fears of being perceived as 'weak' may lead children to conceal their distress, refrain from talking about their feelings, and delay seeking or accepting support until crisis (Chase et al., 2008; Lustig, Weiner, Saxe & Beardslee, 2004; Whittaker, Hardy, Lewis & Buchan, 2005). In summary, the literature indicates challenges increasing not only the accessibility, but also the acceptability of therapy for unaccompanied children in terms of stigmatising associations and distrust of professionals.

1.4.2 Approaches to therapy

The literature review did not locate studies of using trauma-focused CBT specifically with unaccompanied children. Instead, examples were found of individual psychotherapy (Melzak, 2009; Stedman, 2003), clinical and educational psychology practice (German, 2004; Groark et al., 2010), therapeutic groups (Heapy, Ehntholt & Sclare, 2007; Schwartz & Melzak, 2005) and a specialist mental health project for unaccompanied children (Austen, Bronstein & Montgomery, 2008). In these examples, therapists describe combining psychodynamic, systemic and narrative approaches as well as CBT and attachment theory. Melzak (2009) argues one model of therapy is insufficient for supporting children and instead employs multi-dimensional approaches, combining psychoanalytic and systemic theory with social and political perspectives and reflections on power and inequalities. Stedman (2003) writes about her therapeutic work with unaccompanied children at the Medical Foundation, describing her approach as drawing on systemic and narrative practices to understand the fragmented threads of children's lives and weave the threads into coherent wholes.

Heapy et al (2007) describe their 12-session therapeutic group for unaccompanied young women, in which attendees were invited to identify topics they wished to discuss. Topics selected included being alone and loneliness, budgeting money, the future, and world politics. Sessions included opportunities to eat and socialise and were co-facilitated by therapists and a social development worker who offered support in the community between sessions. They describe positive outcomes of the group: young women gained an awareness of the commonality of some of their experiences; had opportunities for shared problem-solving to encourage effective coping strategies; and, developed friendships within the group. These examples of therapeutic work contrast considerably with the single model, therapist-led, individual and trauma-focus of the NICE guidelines.

Research also emphasises unaccompanied children's needs for long-term support to help maintain their wellbeing over the course of numerous distressing events (Chase et al., 2008). In her therapeutic work, Melzak (2009) describes long-term relationships of trust as crucial to foster safety and healing for unaccompanied children. She proposes that the focus on short-term treatments and preoccupation with treating symptoms of 'disorders' in the NHS can overshadow children's experiences of loss of attachment figures and need for secure, long-term therapeutic relationships. This literature differs from the 8-12 sessions recommended in NICE guidelines. The conflicting research regarding approaches to therapy with unaccompanied children raises questions regarding the appropriateness of NICE guidelines for this group. This may create a lack of clarity regarding effective approaches to therapy and possible challenges selecting models of therapy to guide therapeutic work with unaccompanied children.

1.4.3 Therapists' roles

Research suggests that although therapists may prioritise children's emotional needs, the primary concerns of children are likely to be their practical and social needs (Davies & Webb, 2000; Kohli & Mather, 2003; Watters, 2001). Some research proposes that children's practical and social needs must be met before commencing therapeutic work (Warr, 2010; Kohli & Mitchell, 2007; Free, 2003). While other

literature argues against delaying therapeutic work until children's situations are stable, due to concern that children may otherwise not receive therapeutic support at all (Braein & Christie, 2011). It is suggested that therapists take on care co-ordinator roles to build relationships with children order to support their emotional, practical and social needs simultaneously (Burnett & Peel, 2001; Evans, 2008). Summerfield (2002) describes recovery as a practical resuming of everyday life and, as such, recommends focusing on sociocultural, educational, religious, and economic activities. Stedman (2003) describes facilitating children's engagement with education, housing, religious, and community networks in order to give their lives normality. The Refugee Council offers a 'therapeutic casework model', which works on three levels: practical; emotional; and, symbolic (Keefe, 2008). Caseworkers respond to refugee people's practical needs and as trusting relationships develop they discuss deeper meanings of practical issues, with regard to associated emotions or what the issues might symbolise. To summarise, the literature indicates debate regarding combining practical support with therapeutic work, as well as challenges to therapists' priorities and roles in relation to unaccompanied children's practical and social needs.

1.4.4 Concepts in western models of therapy

Research suggests unaccompanied children may have little understanding of western mental health and therapy as it is unlikely to exist in their country of origin (Lay et al., 2007). Children may not understand differences between services and professions, and practices in therapeutic work may be alien to this group (Tribe, 2002; Warr, 2010). There are also likely to be considerable cultural differences regarding understandings of concepts fundamental to western models of therapy; such as emotions, the mind and body, and the self in relation to others (Betancourt, Speelman, Onyango & Bolton, 2009; Free, 2003).

1.4.4.1 'Childhood'

Current taken-for-granted assumptions of childhood in western cultures construct children as vulnerable, needing secure attachments and experiencing a period of 'adolescence' in which identity formation is seen to be crucial (Summerfield, 2000). Although labelled as 'children' by the West, in their countries of origin young people may be considered adults. Their experiences of journeying unaccompanied to the UK may also have advanced the independence and maturity of this group beyond those of their peers (Derluyn & Broekaert, 2007). Hopkins and Hill (2010) warn that interpretations of unaccompanied children's needs are often ethnocentric and over-generalised.

1.4.4.2 The 'self'

Unaccompanied children have been found to remark on the individualistic culture of UK (Chase et al., 2008). Guarnaccia and Lopez (1998) highlight how notions of the 'self' are defined differently across cultures. In non-western cultures the 'self' is defined in relation to family or community with less focus on independence, creating 'sociocentric identities'. Whereas, in western cultures the self is defined through distinguishing one's self as an independent individual, creating 'egocentric' identities. Non-western cultures have been observed to understand distress in relation to disruptions to moral and social order, rather than in terms of discrete internal emotions (Summerfield, 2000). Recovery is through traditional healers within communities, rather than professionals, and individual healing is understood as interconnected to wider community recovery (Bracken, Giller & Summerfield, 1995). The values on which western and non-western cultures operate may therefore present challenges for therapists working with unaccompanied children in terms of finding culturally appropriate ways of working in therapy (Lay et al., 2007).

1.4.4.3 'Trauma'

The literature about the concept of trauma raises questions regarding the appropriateness of trauma-focused CBT in the NICE guidelines for unaccompanied children.

The development of the concept of trauma

In contrast to the collective values of non-western cultures, the individualism of western cultures has been central in the development of ideas of mental health and therapy. Summerfield (1995, 2000) describes how religious practices have been replaced by medicine and psychology in the west. He argues that this has created a unique historical and social context for the generation of understandings of distress as an individual rather than social experience. This is implicated in the construction of the concept of individual 'trauma' and the idea of unprocessed 'trauma memories'. In psychological therapies, these memories are considered to require processing or 'working through' for recovery to occur.

Critiques of the concept of trauma

The idea of individual recovery in isolation from social context is described as peculiar to western cultures, leading to arguments against a universal assumption of a need for individuals to work through trauma memories (Bracken et al., 1995). Bracken, Giller and Summerfield (1997) criticise the predominantly individualistic nature of western psychology as implying that distress is a product of individuals' failures to cope. They condemn approaches that ignore political, social and cultural contexts, which they argue should be seen as central. These approaches are thought to risk individualising social problems and decontextualising people's experiences, undermining connections with the social and political context (Summerfield, 1999). As a result, Summerfield (2000) argues that therapy may adjust children to unjust societies, rather than adjusting societies to better meet children's needs.

Rather than a matter of individual 'trauma', Summerfield (2000, 2002) argues that refugee children's experiences are of a broken social world. The problems they encounter are proposed to be moral and collective, rather than individual (Summerfield, 2001). As a result he suggests they need social, political and moral meaning rather than psychological. Referring to the idea of western therapy as morally and politically neutral, Summerfield (1998) suggests that it is not equipped to address human suffering and cannot provide a solution for a broken social world. This raises fundamental questions regarding what therapy can offer to unaccompanied children and the role therapy plays in their lives in the UK.

Critiques of the concept of 'PTSD'

Alongside critiques of the concept of 'trauma', western PTSD models are argued to medicalise and pathologise responses to experiences by labelling these as 'disordered'. Questions have been raised around whether children's responses to their experiences can be considered disordered or whether these are simply natural reactions to extraordinary circumstances (Free, 2003). Timimi (1998) argues that the concept of PTSD privileges western cultural understandings and undermines the value of refugee children's cultures. Children may experience the illness focus of PTSD as pathologising their distress and disregarding their strengths (Kohli & Mather, 2003). Papadopoulos (2002, p.29) raises questions regarding how therapists can respond to refugee people's distress without pathologising or 'psychologising' it. This may be particularly challenging as research suggests 'trauma' has become a culturally valued expression of distress in western cultures. Refugee people may therefore seek the western language of trauma and diagnoses of PTSD from mental health professionals to support asylum applications (Summerfield, 2000, 2001).

Trauma-focused approaches

In addition to critiques of trauma and PTSD, research suggests that trauma-focused therapy may not fit with unaccompanied children's coping strategy of suppressing

emotions by seeking distractions. Cognitive models of PTSD that inform trauma-focused CBT view avoidance of distressing emotions as maladaptive, as this is considered to maintain high levels of arousal and anxiety (Ehlers & Clark, 2000; Vickers, 2005). Whereas therapists view talking as helpful to resolve emotional distress, unaccompanied children may consider talking to cause more problems and distress (Chase et al., 2008). Summerfield (1995) proposes that active forgetting is a normal coping strategy in non-western cultures. Western models of therapy require clients to have safety and stability in their living situations in order to 'work through' emotional experiences. In the UK, unaccompanied children often experience on-going instability and uncertainty, which Melzak (2009, p.382) states could make emotional work 'difficult and often impossible'. Groark et al (2010) therefore argue that children's lack of emotional safety means supporting them with avoidance may be most appropriate at times of heightened insecurity.

Alternative approaches

As an alternative to trauma-focused therapy, Groark et al (2010) propose focusing on therapeutic relationships with unaccompanied children. These children are described as needing close and trusting relationships to provide someone to rely on and look to for guidance, support, information, and security. Drawing on attachment theory (Bowlby, 1982), they describe children searching for attachment figures to provide a secure base for comfort and enable them to cope with distressing situations. Groark et al suggest that it is only once children have a secure base with a consistently available figure, that they might be able to explore their previous distressing experiences in therapeutic work. They note that this fits with Herman's (1997) model of recovery from trauma in which stabilising is the first priority.

Summary

To summarise, the literature indicates challenges interpreting children's needs in ways that are culturally sensitive. Issues are raised regarding finding ways of working that are appropriate to children's cultures and circumstances and do not

pathologise their distress. Questions are also asked of the role of therapy in relation to children's living situations in the UK.

1.4.5 Understandings of therapy in other disciplines

As well as therapists experiencing challenges working directly with unaccompanied children, existing research highlights challenges working indirectly with other professionals and services around understandings of therapy and children's mental health needs. Hopkins and Hill (2010) observe that service providers and social workers hold differing views of the part therapy may play in supporting unaccompanied children. Whilst explaining the role of social activities in enabling children to distract themselves past experiences, one participant argued 'children don't need therapy, they need a life'; in contrast to another participant who expressed their view of therapy as 'vital' (Hopkins & Hill, 2010, p.404-406). Perspectives also differ on the stage at which children might benefit most from therapy. Some professionals refer children for therapy almost immediately, whereas others associate therapy with dealing with the past and so wait until children are settled in the UK before making referrals (Chase et al., 2008).

Difficulties primary care professionals and General Practitioners have in accessing interpreting services and, therefore, correctly identifying children's mental health needs has been found to act as a barrier to appropriate therapy referrals (Summerfield, 2001). Chase et al (2008) refer to an overuse of medication for children's emotional distress, for example giving medication for headaches rather than enquiring about children's mental health, as a further reason why children may experience difficulties accessing therapy via primary care services. A lack of training in identifying children's mental health needs and the impact of immigration status on their mental health can increase the likelihood of these needs remaining unrecognised (Geltman, Grant-Knight, Ellis & Landgraf, 2007). In literature regarding therapeutic work with unaccompanied children, Melzak (2009) discusses the need for indirect work. For example, providing support for significant adults in children's lives to reflect on the child's experiences and their own feelings, as well as to discuss ways of best meeting children's needs. The Well Being Project mental

health service for unaccompanied children (Austen et al., 2008) offers training and consultation to primary care staff to help them identify the specific mental health needs of these children.

1.4.6 Therapists' responses to emotional distress

Melzak (2009, p.383) discusses bearing witness to children's experiences and holding their sometimes 'extreme, complicated and painful emotions' in her therapeutic work. Managing children's and therapists' distress in therapy with unaccompanied children is described as a considerable emotional challenge. In response, Melzak reflects on an urge to turn away from her own and the children's distress, noting when 'faced with the most destructive human acts and their consequences, it is natural to turn away, to close our eyes and to cover our ears' (p.383). Melzak and Woodcock (1991, p.2) report that the 'tragedy and trauma' of children's stories can make it difficult to hold on to therapeutic skills. In the absence of their caregivers, Stedman (2003) discusses challenges of feeling as if she is in *loco parentis* in therapy, intensifying feelings of responsibility towards unaccompanied children.

Simmonds (2007) applies the Drama Triangle (Karpman, 1968) to professionals managing their distress. In therapeutic work, unaccompanied children may be thought of as 'victimised' by 'persecutory' asylum and care systems, with therapists becoming children's 'rescuers'. These positions are conceptualised as defensive traps that 'perpetuate themselves endlessly and do not stimulate growth' (Simmonds, 2007, p.12). This suggests therapists working with unaccompanied children may experience challenges not only managing emotional distress, but also doing so in ways that hold onto therapeutic skills and sustain the work. Furthermore, Simmonds (2004, p.74) describes unaccompanied children as being at the margins of society and suggests therapists may experience similar marginalisation in therapeutic work with this group. He writes of therapists finding themselves in an 'in-between space' without a membership group as a basis of their legitimacy.

1.5 Summary of literature review

Unaccompanied children are likely to encounter a range of experiences that are thought to cause considerable distress. Research on children's wellbeing is somewhat polarised; highlighting ways in which children demonstrate both psychological vulnerability to mental health problems, but also psychological resilience through adaptive and protective coping strategies. Reviews of services indicate inadequate responses to unaccompanied children's needs in multiple areas of their living situations, meaning children are likely to have numerous unmet needs in their lives in the UK, including their mental health. Concerns have been raised with regard to:

- A lack of research to shape appropriate responses to children's mental health needs;
- The cultural appropriateness of mental health services for this group;
- Potential reluctance of mental health professionals to engage in therapeutic work with these children due to uncertainties about the helpfulness of therapy in the context of their practical circumstances and temporary asylum status.

There is a paucity of research specific to therapy with unaccompanied children to guide therapists in their work. Existing research about therapeutic work with this group, refugee children and social work with unaccompanied children indicates a number of challenges, including:

- Complexities of ensuring the accessibility and acceptability of therapy;
- Questions regarding the appropriateness of western concepts and models of therapy for children from non-western cultures;
- Concerns about the fit between children's needs and the context of the NHS and NICE guidelines in which therapists work;
- Issues around the fit between therapists' roles and children's practical and social needs;
- Difficulties working to improve children's mental health in a context that may be detrimental to their wellbeing;
- Difficulties managing the emotional impact of the work on therapists.

1.6 Rationale for research

There is a lack of research regarding mental health service provision and therapeutic work with unaccompanied children, despite literature suggesting numerous concerns and challenges. Reviews point to a need for more research in this area to inform and improve practice. The rationale for the present research was therefore to generate findings to add to existing literature about therapeutic work with unaccompanied children. It was hoped that this would widen the knowledge base that informs psychological theory and practice, in order to help those working in services that come into contact with these children.

1.7 Research questions

Given the concerns and challenges identified in the literature review, this study focuses on therapists' accounts of their experiences and responses to challenges in therapeutic work with unaccompanied refugee young people. Three specific questions were developed to guide the research:

- i. How do therapists experience their role in their work with unaccompanied refugee young people?
- ii. How do therapists experience employing available models of therapy in their work with these children?
- iii. How do therapists experience the social context of their work with this group?

The aim of these questions was to guide the development of a provisional theoretical understanding, from therapists' perspectives, of therapeutic work with unaccompanied refugee young people.

Chapter 2: Methodology and Method

Chapter 2 begins by describing the epistemological position taken within the research. Grounded theory was selected as a useful and appropriate methodology for the research. In relation to the methodology a description is provided of grounded theory and, more specifically, social constructionist approaches; as well as the rationale for employing grounded theory. With regard to the method, the chapter outlines the data collection and analysis procedures followed in the research. Finally, an account is given of the researcher's position within the research and the criteria employed to evaluate the study.

2.1 Epistemological position

2.1.1 Description of epistemological position

A critical realist social constructionist epistemological position was adopted in the research. This position emphasises the importance of going beyond the data 'to add a further layer of interpretation – by setting what is said in a broader historical, cultural and social context' (Harper, 2012, p.92). From this position, realist ontological claims are made about 'pre-existing material practices' and contexts influencing discourses. Relativist epistemological claims are also made that 'we do not make direct contact with the world but, rather, our experience of it is mediated through culturally shared concepts' (Harper, 2012, p.91-92). This position has been criticised for ontological gerrymandering due to perceived inconsistencies in selective realism and relativism (Woolgar & Pawluch, 1985), which is considered to problematise some phenomena but not others (Harper, 2012). To address this critique, the researcher aimed to explicitly name what is considered to be 'real' (e.g. material resources) and what is considered 'socially constructed' (e.g. 'therapy').

2.1.2 Rationale for epistemological position

Adopting both a critical realist and social constructionist epistemological position was considered appropriate for the research. Critical realism was selected to enable the researcher to explore implications of the availability of material resources for children and therapists. A social constructionist epistemology was selected to examine the impact of western cultural constructs, such as 'therapy' and 'mental health problems', on therapeutic work.

2.2 Methodology

2.2.1 Grounded theory

The grounded theory methodology is characterised by an aim to construct inductively driven theoretical understandings of social and psychological processes, 'grounded' in the data from which the understandings are derived (Charmaz, 2006; Tweed & Charmaz, 2012). Grounded theory is defined by a number of strategies, distinct from other qualitative methodologies:

- Researchers are simultaneously involved in data collection and analysis through an iterative process, where analysis guides 'theoretical sampling' to focus further data collection (Charmaz, 2006);
- Codes and categories are constructed from the data, rather than from preconceived hypotheses or pre-existing theories;
- Constant comparisons are employed to compare data with data, data with categories, and categories with categories (Charmaz & Tweed, 2012);
- Analytic memos are written to elaborate categories, relationships between categories and aid the construction of theoretical understandings (Charmaz, 2005).

2.2.2 Social constructionist grounded theory

Grounded theory² has evolved since it was originally developed and become an 'umbrella term' representing a 'constellation' of methodologies (Charmaz, 2009, p.128; Morse, 2009). Whereas early approaches were based on a positivist epistemology, the methodologies now operate on an epistemological continuum from naive realism to social constructionism (Bryant & Charmaz, 2007). Charmaz (2005, 2006, 2009, 2012) has written extensively about her constructivist³ approach. This approach considers research to be socially constructed. Data is seen to be co-constructed by participants and researchers and, rather than 'discovered', analyses are thought of as 'generated' by researchers (Charmaz & Tweed, 2012).

Social constructionist approaches aim to situate studied phenomena in their historical, social, economic and political contexts (Charmaz, 2005). Actions and meanings within data are viewed as not only reflecting, but also reproducing inequalities, power relationships and discourses (Charmaz, 2009). A critical stance is taken by interrogating data regarding inequalities in access to resources and power, and the consequences of social policies and practices (Charmaz, 2005). Researchers are encouraged to attend to how uses of language within data draw on these discourses; particularly through taken-for-granted meanings and implicit assumptions. Reflexivity is valued to enable researchers to take a critical stance towards the impact of their own assumptions on the research process (Charmaz, 2006).

Rather than 'objective' or 'the only viewpoint', analyses are seen to be subjective and as offering one of numerous perspectives (Charmaz, 2009, p.131). Patterns and connections are prioritised over seeking causality or linear reasoning. Indeterminacy and complexity are celebrated over the reduction or oversimplification of data (Charmaz, 2006). Instead of generalisable theories, researchers aim to construct

² In accordance with Charmaz (2006), the term 'grounded theory' refers to both the methodology and theoretical product of the research.

³ While there are accepted differences between 'constructivism' and 'constructionism' in the United Kingdom (UK), Tweed & Charmaz (2012, p.132) note that grounded theory approaches described as 'constructivist' in the United States are consistent with contemporary social constructionist approaches in the UK. 'Constructivist' grounded theory is therefore hereafter referred to as 'social constructionist' for consistency with the epistemological position of the research.

tentative theoretical understandings viewed as 'partial, conditional, and situated in time, space, positions, action, and interactions' (Charmaz, 2009, p,141).

2.2.3 Rationale for employing grounded theory

A qualitative, rather than quantitative methodology was selected in accordance with the research questions. Quantitative research tends towards a potentially narrow and restrictive focus on numbers (Yardley, 1996). Whereas qualitative research emphasises language, participants' experiences (Bryman, 2008) and produces deep data, facilitating the development of 'rich descriptions of phenomena and processes' (Harper, 2012, p.84). The research aims to construct a theoretical understanding of processes within therapeutic work with unaccompanied children based on therapists' experiences. A qualitative research methodology was considered appropriate to achieve this.

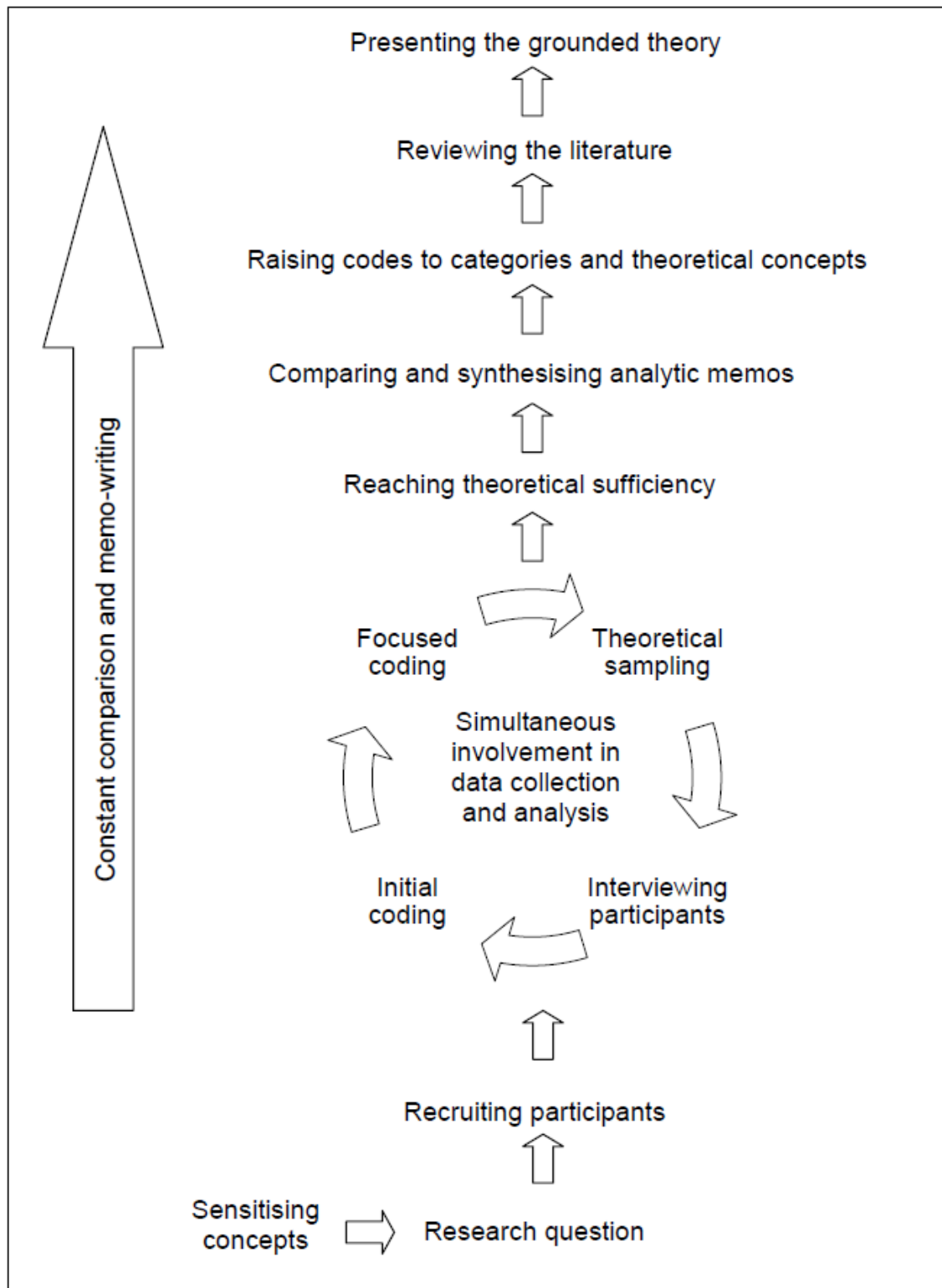
Grounded theory was identified as the most appropriate qualitative methodology for a number of reasons. When choosing a methodology, Henwood and Pidgeon (1992) suggest considering: firstly, the epistemological position of the research; and, secondly, the technicality of which approach is most suited to the research question. Firstly, social constructionist grounded theory is consistent with the epistemological position of the study, as the approach situates social and psychological processes in their material and cultural context (Charmaz, 2006).

Secondly, grounded theory allows researchers to explicate what is '*happening* (or has *happened*)' in studied phenomena (Morse, 2009, p.13) and is therefore suited to research questions about processes within therapeutic work. Grounded theory avoids imposing pre-existing theories on the data. Existing theories and western cultural constructions of therapy might mask and obscure the challenges and complexities of therapeutic work with unaccompanied children. The technicalities of grounded theory were therefore considered well-suited to achieve the aim of exploring these issues. A further aim of the study is to widen the knowledge base informing psychological theories and practice with this group. Henwood and Pidgeon (2003) propose that grounded theory can be employed where existing research is

under-defined or patchy. Given the paucity of studies specific to therapy with these children, this approach was selected to achieve this aim.

2.2.4 Grounded theory strategies

Charmaz (2006, 2009, 2012) outlines strategies for collecting, analysing and synthesising data. This section describes these strategies and illustrates the order in which they are employed (see figure 1).



2.2.4.1 Sensitising concepts

'Sensitising concepts' provide the starting point for grounded theory research, by guiding initial ideas and questions to ask about the phenomena of interest (Blumer, 1969; Charmaz & Tweed, 2012).

2.2.4.2 Use of interviews

Interviewing offers a form of data collection that enables researchers to get close to people's experiences of studied situations. Interviews, however, provide only 'snapshots', co-constructed by researchers and participants within a particular context and relationship (Charmaz, 2005, p.529). Charmaz (2006, p.27) therefore warns it is important for researchers to 'remain attuned' to how they are perceived and to relationships constructed during interviews.

2.2.4.3 Coding

Data coding is the first step in analysis and provides the 'scaffolding' for constructing grounded theories (Charmaz & Tweed, 2012, p.136). Coding involves giving data labels that summarise each segment. Charmaz (2005) suggests summarising *what is happening* by labelling actions and processes. The use of gerunds is recommended to 'make implicit meanings, actions and processes more visible and tangible' (Charmaz & Tweed, 2012, p.137). Coding involves two stages: initial coding and focused coding.

Initial coding involves labelling what the researcher interprets as the actions and processes happening in each small segment of data. *In vivo* codes can be used to preserve participants' own words and meanings (Charmaz, 2006). Focused coding aims to synthesise data fragmented by initial coding into larger segments. Initial codes are grouped and significant or frequently occurring codes are elevated to analytic categories. Focused coding is more selective and conceptual than initial coding, and involves deciding which initial codes make the most sense in the analysis to categorise data incisively and completely (Charmaz, 2006).

2.2.4.4 Constant comparative method

Constant comparisons are employed throughout the research process. The aim of the comparisons is to identify similarities and differences between data, as well as gaps and new leads as part of the process of constructing theoretical understandings. Rather than imposing preconceived notions, these comparisons are intended to support researchers to remain close to the data (Charmaz, 2006).

2.2.4.5 Analytic memo-writing

Memo-writing involve engagement with and analysis of the data alongside each stage of research. Memos constitute the intermediate step between data collection and constructing analyses in three ways. Firstly, memo-writing encourages researchers to record and explore their interpretations, as well as to contextualise data through making links with the social, cultural and material context (Charmaz, 2006). Secondly, memo-writing is used in parallel with constant comparisons to record ideas sparked by comparisons and guide further data collection through identifying gaps and new leads. Thirdly, when synthesised, memos provide the body of the analysis for the construction of theoretical understandings (Charmaz, 2006).

2.2.4.6 Theoretical sampling

Following initial data collection and analysis, grounded theorists engage in theoretical sampling in which further data collection is driven by new leads and gaps identified in existing data (Charmaz & Tweed, 2012). Theoretical sampling aims to develop 'full and robust' categories, clarify relationships between categories, and advance construction of theoretical understandings (Charmaz, 2006, p.101).

2.2.4.7 Theoretical sufficiency

As analyses progress, grounded theorists traditionally aim for 'theoretical saturation'. This is thought to have been 'reached' when gathering further data no longer

'reveals' new information or 'sparks new theoretical insights' (Charmaz, 2006, p.113). The concept has been criticised for foreclosing further analytic possibilities, by preventing researchers from noticing new information and leads. As an alternative to theoretical saturation, Dey (1999) suggested grounded theorists aim for 'theoretical sufficiency' and emphasises continued openness to analytic possibilities through constructing categories sufficiently suggested, rather than saturated, by the data.

2.2.4.8 Raising categories to theoretical concepts

Through the iterative process of constant comparisons, memo-writing, and theoretical sampling, grounded theorists engage in successive levels of analysis to construct abstract theoretical understandings of data. As constructions of theoretical understandings progress, researchers raise some categories to the level of theoretical concepts by assessing their 'carrying capacity'; which entails raising categories that 'carry substantial analytic weight' in accounting for more data and subsuming other categories (Charmaz, 2006, p.139). The ultimate aim of the approach is to construct theoretical understandings that raise some categories to concepts, whilst preserving connections to the data from which they were constructed (Charmaz, 2006).

2.2.4.9 Reviewing the literature

Grounded theorists are encouraged to delay reviewing literature to minimise the imposition of preconceived notions onto analyses. Once independent analyses have been completed, researchers continue analytic work using existing research in the field of study and constant comparisons to compare the literature to the analysis (Charmaz, 2006).

2.3 Method

The following section describes how the grounded theory methodology was translated into practice in the data collection and analysis procedures of the research.

2.3.1 Data collection procedure

This section summarises the methods employed for data collection, including definitions and inclusion criteria for participants, strategies for recruitment, gaining consent, and interviewing participants.

2.3.1.1 Participants

Participants were defined as therapists with experience of working therapeutically with unaccompanied children. 'Therapeutic work' was broadly defined as interventions aimed at improving mental health and well-being. A broad definition was employed to capture the full range of therapeutic work conducted with this group.

2.3.1.2 Inclusion criteria

Two key inclusion criteria were employed to optimise the quality of data. First, participants were required to be professionals with training in therapy; including clinical, educational and counselling psychologists, counsellors, psychotherapists and mental health practitioners. Second, participants were required to have worked with at least ten unaccompanied children to have sufficient experience to draw on during interviews.

2.3.1.3 Ethical approval

The study was granted ethical approval by the University of East London Ethics Committee prior to proceeding with recruitment (see appendix 1).

2.3.1.4 Recruitment procedure

Participants were recruited in 'waves' to facilitate simultaneous involvement in data collection and analysis. This recruitment strategy enabled the researcher to engage in transcription, coding, constant comparisons, and memo-writing to identify gaps and new leads in the data. This informed theoretical sampling in the next 'wave' of data collection. A total of nine therapists were recruited in three 'waves' of four, three, and then two participants.

The four participants in the first wave were recruited through 'convenience' sampling (Morse, 2009). Links were established with a counselling service for unaccompanied children where two therapists were recruited. Two further therapists were recruited through establishing links with individuals at a specialist workshop on therapeutic work with unaccompanied children. Participants in the second and third waves were recruited through 'snowball' sampling in which the researcher invited earlier participants to inform colleagues about the study.

Potential participants were contacted by email and provided with a brief outline of the research (see appendix 2) and an information sheet about the study (see appendix 3). Interviews were arranged with those who responded with interest and met the inclusion criteria. An email was sent confirming the details of the interview and participants were reminded they were free to withdraw their participation at any time. The interviews took place one-to-one in a private room. Seven took place at participants' place of work and two took place in participants' homes; lone working protocols were followed.

The participants represented a range of different forms of therapy training and professional roles and had substantial experience of therapeutic work with unaccompanied children (see table 1).

Table 1: Participants' details

Participant number	Job title	Number of years in practice	Settings worked in with unaccompanied children	Approximate number of unaccompanied children worked with
1	Psychotherapist	18	CAMHS & specialist refugee project	30
2	Educational psychologist	10	CAMHS & specialist refugee mental health service	30
3	Counsellor	8	Generic child services, schools & specialist unaccompanied children service	200
4	Therapist	16	Generic child services & specialist unaccompanied children service	80-100
5	Counsellor	14	Looked after children service	50
6	Mental health practitioner	5	Community centre, voluntary sector service	50
7	Psychotherapist	22	CAMHS & specialist refugee mental health service	50
8	Clinical Psychologist	7	Looked after children service	20
9	Clinical Psychologist	15	Specialist refugee mental health service	50

2.3.1.5 Consent procedure

Before commencing the interview, participants signed a form giving their consent to participating in the study, the interview being audio-recorded, and anonymised quotations being used in the thesis and publications (see appendix 4). The researcher reiterated that participation was voluntary and if they agreed to participate they could decline answering specific questions, take breaks, and withdraw from the study at any time without giving reasons. Participants were informed the interview would focus on the process of therapeutic work, rather than content of work with particular children. They were asked to refrain from discussing children's names or identifying details, but reassured that if these were mentioned they would be omitted during transcription.

2.3.1.6 Interview procedure

One-to-one interviewing was selected as the method of data collection to facilitate in-depth discussions of the studied phenomena. Interviews were conducted using a semi-structured schedule. The flexibility of the semi-structured approach allowed departure from the preconceived interview schedule to gather rich and detailed descriptions, and respond to directions participants took in the interview (Bryman, 2008).

The interviews began with questions about participants' details in relation to their therapeutic work with unaccompanied children; followed by open-ended questions designed to direct discussion and invite narratives, thoughts and reflections (see appendix 6 for the interview protocol). The interview was brought to a close by asking participants whether the most significant aspects of their experiences had been covered and inviting them to add further thoughts. They were invited to give feedback about the interview, to ask the researcher further questions, and thanked for their participation. Participants were informed the interview would last about an hour; however, interviews varied in duration from 1 to 2 hours. This seemed to reflect the different conversational styles and lengths of time available to individual

participants⁴. Interviews were transcribed and analysed immediately afterwards (see appendix 6 for transcription procedure).

2.3.1.7 Interview questions

To develop sensitising concepts at the beginning of the study, the researcher consulted two professionals working in services for unaccompanied children about issues that arise in therapeutic work with these children. The sensitising concepts informed the construction of questions employed in the first wave of interviewing. The questions were then adapted for successive 'waves' of interviews in accordance with theoretical sampling requirements (see appendix 7 for interview schedules).

2.3.2 Data analysis procedure

The following section details methods employed to analyse data, including initial coding, focused coding, memo-writing, raising codes to categories, and concepts and the literature review.

2.3.2.1 Coding

Following transcription of the first interview, data analysis commenced with initial coding. Gerunds were used to summarise what the researcher considered to be happening in each data segment. Initial codes were recorded in the right hand margin of the transcripts (see appendix 8 for an example of initial coding). Where possible, the codes used participants' own words. In the second phase of data analysis, focused coding was conducted through using constant comparisons to group together frequently occurring and significant initial codes considered to share similar properties (see appendix 10 for an example of focused codes). This process was repeated after each subsequent interview.

⁴ The disparity in the duration of interviews is further considered in the researcher's reflexive diary, appendix 13.

2.3.2.2 Analytic memo-writing and constant comparative method

Memo-writing began during initial coding of the first interview and was continued throughout the study. This enabled the researcher to remain actively engaged with the data, guided constant comparisons and directed theoretical sampling. Memo-writing during initial and focused coding was used to describe and elaborate codes with regard to processes, actions, and assumptions contained in the data. Following each 'wave' of data collection, memos were collected and compared to develop 'interim' analyses, which were ultimately developed into the grounded theory of participants' accounts of therapeutic work with unaccompanied children (see appendix 10 for examples of interim analyses).

2.3.2.3 Raising categories to theoretical concepts

As the analysis progressed, focused codes were selectively raised to tentative analytic categories and sub-categories; selected categories were then raised to tentative concepts. Further memo-writing was used to explicate judgements of the carrying capacity of codes. Memo-writing was used to explore the properties of, and relationships within and between, categories and concepts. 'Free-writing' was conducted to record memos aimed at raising selected codes to tentative analytic categories and constructing theoretical understandings of the data (Charmaz, 2006). Visual 'clustering' was used to develop ideas for relationships within and between categories (see appendix 11 and 12 for examples of these techniques).

2.3.2.4 Reviewing the literature

In the present research delaying the literature review was constrained by requirements to submit a brief literature review to the Ethics Committee. Instead, the researcher followed Charmaz's (2006, p.166) recommendation to let the literature 'lie fallow' until after developing an independent analysis. Only then was the literature reviewed and compared with the analysis. The aim of this strategy is to avoid imposing pre-existing theories on the data. However, critics argue that it is not

possible for researchers to suspend their awareness of pre-existing theories in the process of the analysis (Heath & Cowley, 2004; Robson, 2002).

A further issue with this strategy in the present research was that participants themselves were familiar with the literature and drew on pre-existing theories during the interviews to make sense of and articulate their experiences. Charmaz (2006) argues that preconceptions should not provide automatic codes. Instead, she suggests researchers ask themselves whether the data can be adequately interpreted without preconceived concepts and if not, what the concepts add to the interpretations. Rather than taking-for-granted preconceived ideas, the researcher followed this procedure to ensure that these concepts *earned* their way into the analysis.

2.4 Reflexivity

Social constructionist approaches view researchers as 'part of what they study, not separate from it' and emphasise the importance of taking a reflexive stance (Charmaz, 2006, p.178). Researchers are encouraged to reflect on how their interactions, positions and assumptions influence the research process. The following section outlines reflections on the researcher's position, interests and beliefs.

With regard to my position as a researcher, I am a White-British, female, third year trainee clinical psychologist. As well as studying therapeutic work, I am also developing my skills as a therapist. My personal interests and beliefs influenced my decision to study therapeutic work with unaccompanied children and my constructions throughout the research process. My interests pertinent to the research are as follows: I am interested in the influence of social context and the impact of access to material resources on well-being; I am interested in therapeutic work as a significant element of clinical psychology training; I am aware of a 'therapy' as a construct specific to western cultures; and, as a result, I am curious about how therapy is constructed and experienced between western-trained therapists and people from non-western cultures. The situation of unaccompanied children sparked my curiosity with regard to their non-western cultures and

inequalities in access to material resources they encounter in the UK. This led me to question how therapists experience therapeutic work in this context.

2.5 Evaluating the grounded theory

As outlined below, Charmaz's (2005, p.182-183) criteria for evaluating the quality of research in relation to its social context were employed in the present study:

1. Credibility

- Achieving intimate familiarity with the topic;
- Gathering sufficient data to merit researcher's claims, taking into account the range, number and depth of observations contained in the data;
- Making systematic comparisons between observations and categories;
- Ensuring there are strong logical links between researcher's argument and analysis;
- Providing enough evidence for researcher's claims to allow readers to form independent assessments;

2. Originality

- Offering new insights;
- Establishing the social and theoretical significance of the work;
- Exploring how the work challenges, extends and refines current ideas, concepts and practices;

3. Resonance

- Portraying the fullness of the studied experience;
- Revealing taken-for-granted meanings;
- Drawing links between individual lives and larger collectivities;
- Offering deeper insights to members of the studied group about their lives and worlds;

4. Usefulness

- Offering interpretations people can use in their everyday worlds;
- Speaking to generic processes;
- Sparking further research in other areas;
- Contributing to knowledge and making a better society.

Chapter 3: Analysis

Chapter 3 presents an analysis of participants' accounts of their therapeutic work with unaccompanied refugee young people. The chapter begins by outlining the structure of the analysis with regard to concepts, processes, categories and sub-categories constructed from the data. The categories and sub-categories of the analysis are then discussed in relation to theoretical understandings generated from the data. Extracts from interview transcripts are provided to represent the data in which the analysis is grounded.

3.1 Organisation of the analysis

The following section explicates the concepts, processes and categories that were constructed as central components of the analysis.

3.1.1 Central components

3.1.1.1 Responding to children's needs

The central theoretical concept generated in the analysis was 'responding to children's needs'. Participants' constructions of unaccompanied children's needs were divided into: 'practical' needs, including food, housing, access to services and resources; and 'emotional' needs, such as for trusting relationships, being believed and specific mental health needs. The concept 'responding to children's needs' was thought to subsume all other processes occurring in participants' accounts of their therapeutic work.

3.1.1.2 'Holding on' and 'putting aside'

Participants gave accounts of working in a western cultural context and employing western models of therapy; in contrast to unaccompanied children's non-western

cultures. In working with this group, participants were required to navigate western and non-western cultures. This navigation process gave rise to a 'bicultural' experience. Responding to children's needs in the context of this bicultural experience created challenges for participants. The ways these challenges were managed were conceptualised as entailing a balancing process of 'holding onto' and 'putting aside' different elements of therapy to respond to children's needs. In some instances, participants did this simultaneously as a permanent feature of their ways of working. Whereas at other times, they seemed to alternate between holding onto and putting aside certain elements of therapy; at these times putting aside was therefore a temporary process before holding onto western therapy was restored.

3.1.2 Categories and sub-categories

The concept 'responding to children's needs' and the processes 'holding onto' and 'putting aside' are interwoven throughout the analysis. These central components subsume three categories, which each contain a number of sub-categories (see figure 2). The three categories are summarised here and presented in detail over the course of the chapter. The first category, 'meeting children where they are', explores participants' responses to children's needs in relation to beginning therapeutic work. The second category, 'balancing boundaries', considers challenges of responding to children's needs in the context of western models of therapy. Lastly, the third category, 'managing positioning', discusses participants' constructions of their positions in relation to children and the UK socio-political context.

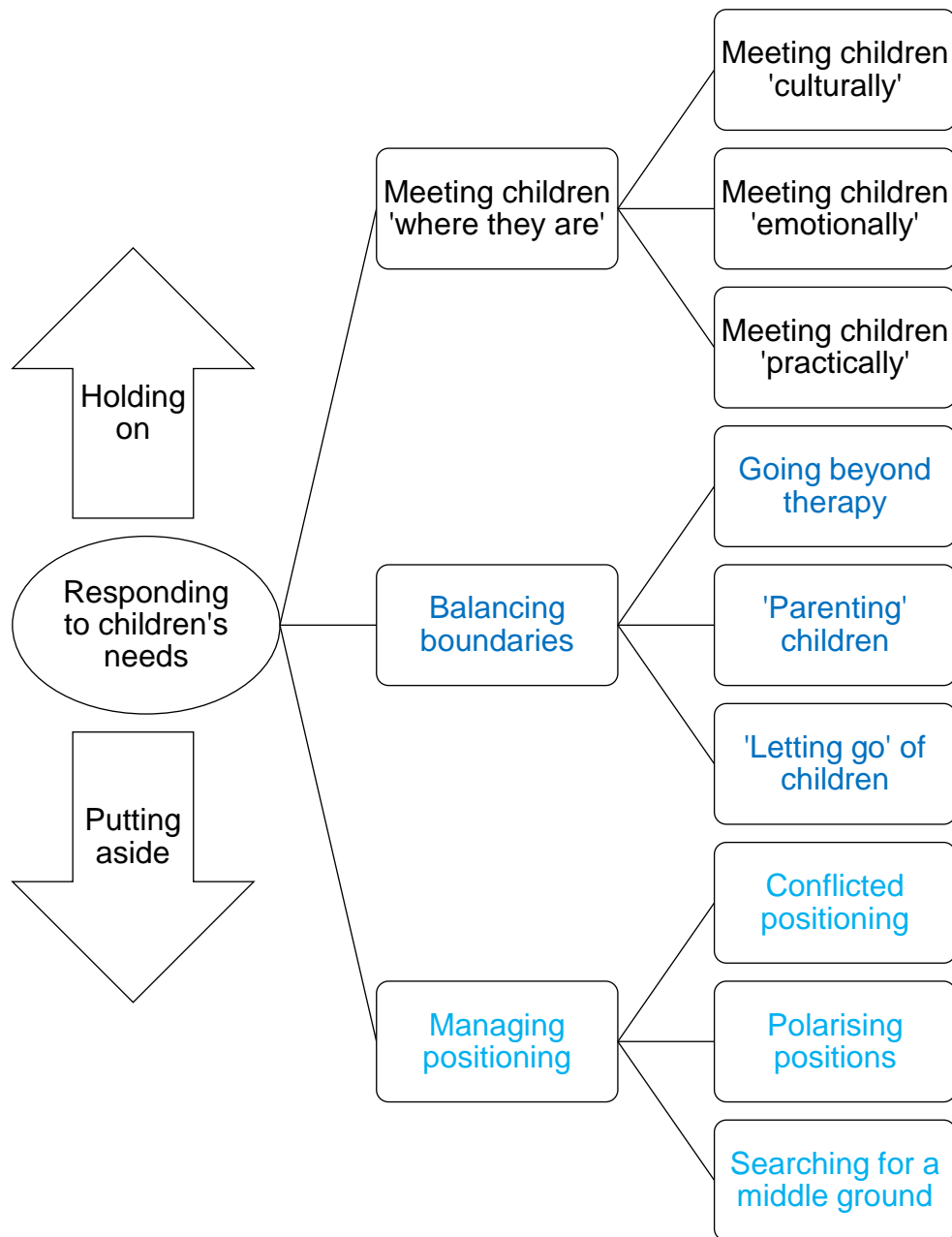


Figure 2: Chart showing hierarchical relationships between concepts, categories and sub-categories

During the interviews, participants' narratives spontaneously followed a structure of describing children's experiences and needs arising from these experiences, in order to contextualise their responses to these needs. The following sections mirror participants' narratives by presenting their constructions of children's needs first, before conceptualising their responses.

3.2 Meeting children ‘where they are’

The phrase ‘meeting children where they are’ was constructed from an initial *in vivo* code (5, 183⁵). This code represented a number of different meanings. Participants used the word ‘meeting’ in a literal sense to indicate meeting face-to-face at particular locations; as well as in a metaphorical sense to symbolise meeting children through ‘joining’ with their cultural practices, emotional experiences and practical needs. Meeting children ‘where they are’ therefore represented a process of fitting therapeutic approaches around children, rather than fitting them into therapy models. Beginning therapeutic work involved responding to their cultural, emotional and practical needs. The following section examines participants’ approaches to meeting children ‘where they are’ in relation to each of these needs in turn.

3.2.1 Meeting children ‘culturally’

Meeting children ‘where they are’ meant participants adapting their familiar therapeutic approaches to respond to children’s non-western cultural backgrounds, which was understandably reported to be challenging. Participants described two particular challenges: children not having a concept of ‘therapy’ and difficulties translating western concepts across cultures. Responding to these challenges involved: firstly, not making assumptions about children’s knowledge; secondly, developing shared understandings of western concepts; thirdly, working to translate ‘therapy’ across cultures; and finally, employing western models of therapy flexibly.

3.2.1.1 Not making assumptions

Participants were aware that children might not have previously encountered the concept of therapy, and may have frequently encountered the opposite. At the beginning of therapy, participants observed children not understanding taken-for-granted western concepts, for example the concept of confidentiality and the notion

⁵ For quotations from interview transcripts, the first number in brackets refers to the participant number and the second refers to the line number in the transcript.

'talking helps'. Western therapy practices were also alien to children, such as sitting one-to-one in a room and talking about personal feelings with non-family members. As a result, participants noted children sometimes responded to the idea of therapy with suspicion or rejection.

'there's no shared understanding of therapy...Why is the door to the therapy room shut? Why are there only two of us in the room? Once I tried to explain confidentiality and the boy just walked out, they need to know that we can advocate for them and share...with their permission when it's helpful. The idea that saying something on its own is helpful is alien...They don't know how...therapy could help' (5, 69-75)

In response, participants adapted their approaches by not assuming shared understandings and instead actively making practices within therapy explicit. One participant gave an account of explaining the process of arriving to therapy appointments, rather than assuming children knew what to do:

'the problem with accessing other services is that there are assumptions that they know what to do. When young people come here for the first time we show them round...and explain, this is our office manager...she will answer the door...she will ask you to wait in this room...We're really explicit about the process, otherwise it can cause so much confusion' (3, 169-176)

Participants also spoke of not assuming children understood divisions between different social structures in the UK. Children were constructed as fearing therapists worked for the Home Office and might therefore intend to check the 'truth' of their story. Meeting children 'where they are' therefore meant explicitly setting therapy apart from the asylum system.

'we do explain that we are not the Home Office...we are not any other agencies. That we work with them for their own benefit' (7, 138-140)

Despite giving accounts of working to make their assumptions explicit, some practices were so ingrained they continued to be taken-for-granted. For example, the closed door of the therapy room could be seen to represent western concepts of 'privacy' and assumptions that children would talk about 'private' matters. Although

polarised positions were constructed of 'making everything explicit' in contrast to other services 'making assumptions', this demonstrated the complexities of this process and that participants were perhaps actually working in the middle between these two opposites.

3.2.1.2 Developing shared understandings

The process of developing shared understandings of the concept of therapy was constructed as essential for therapeutic work to proceed. Participants gave accounts of adapting their approaches by working to connect to children's experiences of talking about difficulties in their country of origin, in order to explore parallels with western therapy practices. Developing shared understandings could be time-consuming, which was framed as problematic when the duration of therapy was restricted.

'it might take someone a session to catch on to what therapy is, it might take them the whole five sessions and then we've only got one session left' (4, 503-505)

Participants noted that the process required children to have enough vocabulary to be able to explain and share their understandings. Children were sometimes unable to fully articulate their ideas in a second language or did not have enough shared concepts in their first language for their understandings to be interpreted. Developing shared understandings was therefore constructed as an uncertain process, in terms of not knowing whether they had been successful.

'she would come and present symptoms...I, many times, had said to her, "I'm not a doctor and I won't be able to give you medication". I thought that's why she's repeating these symptoms. In retrospect, we couldn't find any kind of ground where we could understand the therapeutic endeavour' (1, 664-669)

In response to this uncertainty, participants described additional adaptations to their approaches to further facilitate developing shared understandings. Including comparing their roles to other professionals with whom children were more familiar,

pragmatically distilling the aims of therapy down to basic elements, and engaging in a process of clarifying details of children's understandings.

'if all else fails we just say "if there's problems on the inside and in here [pointed to head], that's us and if it's on the outside it's your social worker"' (3, 177-179)

'I might say "so can you tell me what counselling is?"...sometimes they go "oh it's a place to come and talk about my past" and I sort of go "you can...also talk about the present or future, anything that's worrying you"' (4, 346-349)

3.2.1.3 Translating 'therapy' across cultures

Participants spoke of experiencing difficulties translating concepts in therapy across cultures and noticing that many western social constructions were not shared by children's non-western cultures, such as the individual 'self' and certain emotional states.

'when we started we were based on using a western counselling model...we very quickly realised that those concepts didn't translate across cultures...sometimes language, but just culturally' (3, 187-191)

To navigate working with their own western cultures and children's non-western cultures, participants balanced holding onto and putting aside certain elements of therapy in order to employ western models flexibly. This process is described in the following sub-sections.

Holding onto western concepts

Despite difficulties translating 'therapy' across cultures, participants constructed certain western concepts as helpful; both for themselves and children. Concepts such as those from psychodynamic theory were framed as useful for participants to articulate and validate their emotional experiences of their work.

'a lot of the terms that I was introduced to on my training courses, I can remember being so relieved to hear. It was like someone giving me words for what I was experiencing but couldn't explain...like transference, projection' (6, 155-159)

Participants spoke of western therapy models guiding hypotheses about children's needs and providing tools for supporting these needs.

'it gives you some more tools to hopefully help you to understand what your clients are going through' (6, 198-199)

For example, participants referred to western concepts of 'identity' and 'adolescence' from Erikson's (1959) stages of development model in their accounts of supporting children's perceived 'identity formation' needs (1, 755). Although they spoke of western constructs of the individual 'self' not being shared across cultures, their accounts indicated certain western concepts were taken-for-granted; perhaps demonstrating the challenges of navigating two cultures in the therapeutic work.

Putting western concepts aside

Participants constructed certain elements of western therapy as hindering their work. When western and non-western concepts were experienced as too different, they made decisions to dispense with western concepts in order to meet children 'where they are'. One participant discussed working with children for whom CBT notions of individual thoughts and feelings were irreconcilably different from their own cultural concepts. This was described as a disorienting experience that displaced the participant from familiar concepts and models.

'I really had to put aside my western model...the concept of having an individual life goal or an individual future separate from other people just wasn't understood. And we found ourselves kind of sitting opposite each other and being from two different worlds...I had to unlearn a lot of what I'd learnt' (3, 195-216)

Western concepts were also dispensed with when irreconcilable with current children's experiences. Participants constructed 'resolution' of past trauma as sometimes incompatible with children's experiences of trauma 'happening' rather than 'happened' (4, 524) and instead focused on supporting children to manage their present experiences.

'a lot of western models are based on resolution and change...our young people are not in a position to do that...they know that in a year's time their visa runs out and they could be returned...so we literally have to focus on just managing what is happening' (3, 465-474)

3.2.1.4 Employing western models of therapy flexibly

Rather than fitting children into western therapy; participants described flexibly selecting and adapting therapy models in order to fit their therapeutic approaches around children. Where children 'are' is partly in their own culture and partly having to acclimatise to the host culture; balancing holding onto and putting aside western concepts was therefore considered appropriate for therapeutic work.

'not being too focused on the individual and internal worlds, keeping that balance of other factors...I really feel when working with these young people therapeutically you've got to have the freedom to be dynamic...there's certain things...that just didn't fit...perhaps not exploring enough cultural reasons why a person might behave the way they do...I wanted to take it in different directions, take a holistic perspective...put them together and work flexibly' (6, 215-257)

A balancing process was constructed in relation to the concept of PTSD, which was framed as having the potential to be both helpful and unhelpful for children. Participants viewed PTSD as helpful for reassuring and normalising children's experiences of symptoms associated with the diagnosis and for reports written to support children's asylum applications. Concerns were also expressed about unhelpful consequences of the diagnosis. Including, privileging western explanations over non-western understandings and reducing children's difficulties to a mental

health problem. In response, participants balanced using the concept with drawing on children's cultural understandings and considering their experiences within the social context.

'not just an either or, let's talk about PTSD, particularly when I'm writing a report for court. Now let's talk about it in another way also, "how do you understand it? What do you think the dreams are saying to you?" Allow for a multiplicity of explanations' (1, 548-551)

'they might have PTSD features...but also they manage to function...unaccompanied minors are embedded in such a variety of complex networks, how they get on at school and what they do in their social life are equally important' (8, 284-294)

3.2.2 Meeting children 'emotionally'

Participants described understanding children's experiences of living in the UK as essential to responding to their emotional needs. In particular, they referred to children's experiences of: 'interrogation' upon arriving in the UK; the culture of disbelief towards refugee people; isolated living situations; and, a distrust of professionals. Participants' awareness of these experiences informed adaptations to their therapeutic work to relate to children in ways that supported relationship building.

3.2.2.1 Following children's lead

When children arrive in the UK participants were aware that encounters with the asylum system can be distressing and that children may fear similar encounters in therapy. In response, they put aside elements of therapy constructed as having the potential to replicate these experiences. Rather than conducting 'conventional' therapist-led assessments to gather information and formulate psychological difficulties, participants gave accounts of refraining from asking for information. Control was relinquished in order to 'follow children's lead', thereby holding onto

client-led approaches and giving children choice to share information when they were ready:

'they have a series of interviews after interviews and interrogation after interrogation so they come quite exhausted. Interrogation will be the last thing they want from a professional like myself who intends to offer them therapy...When I see them I don't take notes. It's just a brief conversation, just being there with them' (7, 75-80)

3.2.2.2 Going against the culture of disbelief

Participants noticed the disbelief about the veracity of refugee people's reports caused children much emotional distress. They framed models of 'neutrality' in traditional therapy as problematic, due to risks of implicitly reinforcing children's experiences of disbelief. Participants therefore spoke of permanently dispensing with 'neutrality' and instead adopting non-neutral positions. For instance, by explicitly stating their positive views towards refugee people:

'if you don't believe in some of the issues refugees have and you're not of the political mindset that they are welcome, that's going to come a cropper, because the culture of disbelief is so strong...If you are in a service where "if you are a refugee then you are welcome" you see that person in a different way...our service has got that upfront' (2, 160-167)

Participants were mindful that children's experiences of the asylum system could cause them to feel devalued. They therefore spoke of offering children different, therapeutic experiences to make them feel valued through: showing positive regard; respecting their cultural traditions and religious practices; demonstrating they care about things that happened to children; and, holding hope for children's futures.

'if we can just show a young person who has gone through so much that they are valued, that to me feels like the start of healing' (3, 430-431)

3.2.2.3 Being there

In relation their isolated living situations and uncertain asylum status, children were thought to experience a lack of emotional safety and stability. By adapting their approaches to simply 'being there', participants spoke of endeavouring to be reliable figures in children's lives and make up for their lack of safety and stability:

'we become their constant figure...it's providing stability...something they don't have' (4, 470-477)

Participants' understandings of the therapeutic value of 'being there' were informed by holding onto certain elements of western therapy. They spontaneously referred to attachment theory (Bowlby, 1982) to explain a process of developing secure attachments and providing a secure base from which children could explore unfamiliar social structures. The attachment process was framed as essential to therapeutic work and enabling children to settle in the UK.

'that creation of a secure base...the sense of safety...that somebody is there for you...that's absolutely crucial...more crucial perhaps for unaccompanied young people' (1, 729-739)

3.2.2.4 Building trust

Participants were cognisant that children may be distrusting and wary of others. Meeting children 'where they are' therefore involved a number of considerations: understanding reasons why children may be wary; appreciating that assuming others are untrustworthy can be adaptive; and, sometimes, encouraging children to be cautious about who they trust to protect themselves.

'we don't want them to develop too quickly a trusting relationship...we need to reinforce that they need to check out who we are...I will say "you need to be really careful about who you talk to about your life, how can I help you to judge that?"' (3, 456-462)

In their narratives, participants simultaneously supported children's distrust of others, whilst also positioning themselves as an exception to the rule. Although this gave children conflicting messages, having someone they could trust was constructed as crucial for children's well-being. Building trust was framed as essential for therapeutic work to proceed. On this basis, participants spoke of temporarily putting aside specific therapy 'techniques' to focus on getting to know each other and, over time, build trusting therapeutic relationships:

'we focused on just forming a connection and left everything else...if we achieved that, it worked' (3, 224-228)

3.2.2.5 Using fundamental therapeutic skills

Participants' narratives constructed therapy as involving two stages with different aims, which required different therapeutic skills. The aim of the first stage was building trusting therapeutic relationships; whereas, the aim of the second stage was responding to specific mental health needs, for example supporting children with experiences of 'depression'. Participants' descriptions led to the idea of distinguishing 'primary' skills, 'fundamental' to relationship building from 'secondary' skills. Secondary skills were framed as specific techniques employed to respond to mental health needs; for instance using CBT to support children with 'negative automatic thoughts'. Although helpful later in therapy, secondary skills were constructed as potentially hindering relationship building in the first stage.

'it doesn't matter what you do, if you're amazing at relaxation or negative automatic thoughts. If they're not going to like you they're not going to come back' (8, 231-233)

'Using fundamental therapeutic skills' involved putting aside secondary skills as a temporary measure at the beginning of therapy to hold onto primary skills. Therapeutic skills discussed by participants as fundamental to relationship building included listening, giving children space to share their distress, communicating empathy, witnessing, and acknowledging their distress.

‘what I was doing was as simple as just helping to hold someone and just be there for them and just listen and maybe bear witness to some of the things that they had seen’ (6, 173-175)

‘fundamentally it’s about making a relationship with another person...you’ve got to use the evidence base, but I think you can incorporate that afterwards, once you have the basics’ (8, 223-230)

3.2.3 Meeting children ‘practically’

Participants gave accounts of responding to children’s unmet practical needs by adapting their approaches in order to do practical tasks with children as part of the therapeutic work. Responding to children’s practical needs created dilemmas in relation to ‘conventional’ models of therapy. These dilemmas and participants’ responses are discussed in the following sub-sections.

3.2.3.1 Dealing with dilemmas

Ethical and moral dilemmas were considered to underlie participants’ decisions to meet children’s practical needs. They spoke of therapists abstaining from doing practical tasks in conventional therapy models and referred to dominant discourses about ‘good’ therapists, working in the context of the NHS, and NICE guidelines. This raised the question: “what kind of *therapist* am I if I put these conventions aside?”. However, children’s perceived ‘neediness’ created a polarised ethical dilemma of: either holding onto conventional therapy models and potentially leaving children’s needs unmet or putting conventions aside and meeting these needs. This connected to a moral dilemma of: “what sort of *person* would I be if I did not respond to these children’s needs?”. At times participants seemed to struggle between two opposing perceptions of themselves: wanting to be a ‘good’ therapist as well as wanting to be a ‘good’ person.

‘there is something about this that is largely a personal and human endeavour and don’t be afraid to jump into that. I think I got caught up for a

long time with this “is this right?”, “should I be doing this?” and “is this therapy?” but just trust that this is what needed’ (1, 998-1002)

Participants resolved these dilemmas in two ways. Firstly, rather than confining their therapeutic work to ‘conventional’ models, they constructed these conventions as ‘restrictive’ and gave accounts of deconstructing discourses about what ‘good’ therapists ‘should’ do. This seemed to enable participants to reconcile putting these conventions aside and temporarily drop the roles for which they were trained and paid, in order to work flexibly and take on ‘care co-ordination’ roles.

‘We can be too precious about what we’ve learned in therapy training...I had to deconstruct what I’d learned about counselling and discourses about what a ‘good’ therapist should do’ (5, 47-49)

‘with the immediacy of the practical problems that come up, we need to do something different...the role we have is much more flexible than the conventional counselling role’ (3, 130-139)

3.2.3.2 Moving from the practical to the emotional

Secondly, participants resolved these dilemmas by positioning themselves as both ‘good’ therapists and people, through constructing practical tasks as enabling them to work towards focusing on their emotional needs. At the beginning of therapy, they described children as more concerned about their practical than mental health needs. Doing practical tasks was constructed as facilitating trust and relationship building through: enabling participants to follow ‘children’s lead’; showing that they cared about issues important to children; demonstrating their flexibility and reliability in responding to children’s needs, perhaps in contrast to the relative inflexibility of the asylum system; and, giving children hoped for positive results to increase children’s engagement in therapy.

‘not just jumping into the trauma aspect of it because often it’s their living conditions that they bring, the hassle to do with the legal system or their housing...you’re more flexible than just sitting in your therapeutic room and

work on those practical issues, you do a little bit of trust building and they trust you...they see that you actually care about what they bring' (2, 123-128)

'once they start to see solid results from what you do, like helping them find a good solicitor and helping them to live in a house that they feel comfortable in and getting more support from social services, trust will grow' (6, 336-338)

As trusting therapeutic relationships developed, participants gave accounts of children gradually sharing information about their emotional wellbeing. One participant referred to Lemma's (2010) idea of 'mobile conversations' to describe practical work as providing opportunities for therapeutic conversations whilst 'on the move' (6, 347). These conversations were framed as gradually moving the work from a practical to an emotional focus. Constructing practical work as facilitating relationship building therefore provided a further way for participants to resolve tensions between being a 'good' person and therapist.

'once that trust develops then you go to another phase where they start to tell you...what their nightmares are about, what is really personal' (2, 129-131)

'as this trust develops...and you're sitting on the tube or you're walking to the shops with them, those spaces seem to create an emotional opening...those conversations seem to precede the conversations you'll have sitting in a room like "okay let's talk about how you're feeling and think about how I can help you feel better"' (6, 340-346)

Putting aside therapists' conventional roles was viewed as a temporary measure, before they were restored in the second stage of therapy. This suggests a linear movement from the first to the second stage; however, participants noted that practical needs re-emerged over the course of therapeutic work due to the 'unpredictability' of children's lives (3, 150). Movement between the two stages was therefore circular, as the focus altered between children's practical and emotional needs in accordance with changes in their living situations.

3.3 Balancing boundaries

Once trusting relationships were established, participants gave accounts of further challenges over the course of the therapeutic work. In response to their constructions of children as vulnerable and in need of support, they positioned themselves as feeling ‘compelled’ to respond to children’s needs. When the needs were beyond the bounds of ‘conventional’ therapy models, participants experienced challenges balancing boundaries of therapy with feeling ‘compelled’ to respond.

‘there’s something about this kind of work that it’s particularly hard to draw the boundaries...it’s some of the most distressing work. Just meeting a young person who’s lost their family, it can be incredibly upsetting... there’s a limit to how much you can do as a clinician and what your role is. So I think there’s a bit of a dilemma’ (9, 44-51)

Underlying these challenges was thought to be a polarised ethical dilemma of: either holding onto professional codes of conduct and not meeting children’s needs, or putting these boundaries aside and meeting children’s needs. This seemed to create tensions between boundaries and flexibility, which pulled participants in opposite directions. The following section explores examples of challenges regarding going beyond western constructions ‘therapy’, ‘parenting’, and ‘letting go’ of children at the end of therapeutic work.

3.3.1 Going beyond ‘therapy’

Participants described children’s needs as wide-ranging and requiring support from professionals of diverse disciplines. When children’s needs were met by multidisciplinary teams, participants spoke of remaining within the bounds of their roles as therapists and maintaining a focus on children’s mental health.

‘They have social workers who can contact them at home at anytime, it’s their role to do that. So that helps to protect my position’ (7, 179-181)

When children’s needs beyond that of therapy were not supported by other professionals, participants described a magnified sense of feeling compelled to

prioritise flexibility by going beyond 'therapy' in order to compensate for the absence of support and respond to these needs.

'It feels like we need to know more and more... There are more and more cut backs that means there's less and less support around' (4, 868-876)

Participants' narratives indicated that it was sometimes not possible to be a 'good' therapist remaining within their boundaries as well as a 'good' person doing enough to respond to children's needs. When children were perceived as needing more than therapy, they gave examples of making ethical decisions to temporarily put concerns about being 'good' therapists aside to carry out work that migrated across a range of roles; such as that of caseworkers, teachers, advocates, social workers, support workers, and organisers of day trips for groups of unaccompanied children.

'what I was doing was stretched beyond therapy...it wasn't just to be a therapist, so I found myself responding to what I perceived were needs for an advocate, to do some kind of social work...to make connections with other agencies and pull things together...I was doing more of this kind of work...I felt it would have been unethical to not respond to it in some way' (1, 293-321)

They also spoke of going beyond the boundaries of their role to avoid saying "no" to children. Not responding to children's needs was thought to create intolerable guilt for participants in relation to the ethical dilemma of leaving their needs unmet. Putting boundaries aside to respond to their needs therefore relieved this guilt.

'maybe stretching those boundaries made it possible that I didn't have to say "no" so often, which is interesting because that seemed like a hard thing to do' (1, 460-462)

Putting boundaries aside involved participants 'going the extra mile' (9, 173) by working longer hours and doing more for children. Although relieving guilt, going beyond therapy was described as sometimes involving doing too much to meet children's needs, resulting in participants neglecting their own needs. In response, one participant spoke of a process of finding a balance between doing enough to

respond to children's needs, but not doing too much that it disrupted boundaries between their work and personal life:

'I don't know if I've become a bit hardened but I'm aware of needing to go home to my own family and leaving it behind, I think I've become quite good at doing that. Earlier in my career I would have had more sleepless nights, but now...I don't think I take things home in a way that I resent or in a way that could impact on my home life' (9, 165-172)

3.3.2 'Parenting' children

In the absence of their families, children were constructed as looking to others to meet needs that would otherwise be met by their families. Participants experienced children relating to them as parents. For instance wanting to be their lost family members, looking to them for guidance their families would have given and wanting them to provide homes they would otherwise have had with their families. Participants responded in a number of different ways. Children were experienced as 'projecting' feelings of wanting to be taken home (2, 334) and, in response, participants described identifying with these perceived projections through phantasies of taking children home with them.

'myself and my colleague allowed ourselves these ridiculous conversations where she'd say "what do you think my husband would say if I came home with 'blogs'?"...We'd kind of allow ourselves these phantasies...we knew it was ridiculous, but it spoke to...the strength of the emotional response that I had to these young unaccompanied people' (1, 955-964)

At those times, participants were careful to communicate that taking children home was a boundary they would not transgress within their work. Instead, they constructed themselves as holding on tighter to boundaries of therapy, for example by reducing over familiarity with children and by discussing the limits of their role; perhaps to establish emotional distance from children. This seemed to represent the tensions between flexibility and boundaries in therapeutic work.

'you have to again be explicit that you're not going to be able to be the mother that they are missing, not as brutal as that but...it's really asserting that perimeter...you can't take all of your unaccompanied minors home as much as you would want to, but you can help in other ways' (2, 345-354)

Participants described finding ways to compensate for the absence of children's families; indicating a taken-for-granted values stance that children should not be without family. They spoke of developing stronger relationships with these children. Instead of literally taking children home, also participants noticed themselves thinking of particularly isolated children outside of work. Thereby taking them home metaphorically, through internalised 'representations' of children:

'There's something about just constantly being aware of how isolated they are...the attachment with unaccompanied minors it's much stronger than...with any other client group' (4, 617-626)

'Almost taking them home mentally...It's something about them being held in mind...if not in the house [laughter]' (1, 983-988)

Connected to going beyond therapy, participants spoke of offering support that would normally be provided by: parents, such as supporting children to navigate systems; other family figures, for example providing guidance that might otherwise be given by sisters or aunts; and family units, for instance by working with other professionals to form surrogate families to support children.

'if we refer them somewhere we might still have to follow that up...we have to do some of the parental work which would normally be taken up by their parents' (4, 733-737)

'that young person begins to see that their team, that second family, is holding them in mind' (2, 213-214)

'we needed to not be working in a dyad with an interpreter, we needed to be in a triad, it needed to be a family unit' (3, 238-239)

Participants gave competing accounts of wanting to hold onto their role as a therapist, whilst also questioning the usefulness of therapy in the absence of

children's families. On one occasion, a participant spoke of having considered leaving the therapy profession altogether to meet unaccompanied children's needs for a family and a home:

'I remember thinking "what you need is not a therapist but just to come and live with us...and you'll be fine"...Therapy can be helpful I do believe that, but often these young people need a loving home' (9, 54-58) 'It's made me wonder about becoming a foster carer' (9, 175)

3.3.3 'Letting go' of children

Bringing to an end the very relationships participants had worked so hard to establish was framed as particularly challenging. As a result, participants described experiencing difficulties ending therapy and 'letting go' of children.

'in an NHS setting there's often a sense of time limited work and that felt really difficult to cut that time off...That just felt almost impossible' (1, 298-301)

'I was always aware of how powerful this scared feeling of talking about an ending and they're telling you in supervision "do you think you need to end now?" and I'm scared because the attachment is very powerful...they aren't just attached to you, you're attached to them as well' (4, 629-640)

Participants developed a number of ways of maintaining contact with children after the end of therapy. Weekly open drop-in groups and children informally visiting participants at their services were ways of maintaining contact that were considered to be within the bounds of therapy. Participants who had moved to work in different services, however, were unable to maintain contact in this way. Sharing their telephone number with children was described as an alternative way of maintaining contact.

'normally I would never ever, I don't think I have ever given my number to other clients, but there was something about knowing that many of these young people were completely isolated, completely alone that maybe just

having somebody's phone number might make such a difference... finding myself doing things I wouldn't usually do and having to kind of make sense of that' (1, 370-377)

This was constructed as an exception, indicating that it was considered to be beyond the bounds of therapy and professional codes of conduct. However, maintaining contact was constructed as serving important functions both for children and participants.

'we don't let those clients go. Now I think that says more about us than it does about them, well no I think it's probably equal...it does serve a need for them, but I think it also serves a need for us' (3, 375-383)

For children, maintaining contact was framed as reducing their isolation and giving them a continued sense of someone 'being there' for them. For participants, maintaining contact meant being able to hear children's news, such as of receiving leave to remain. In the context of many children being deported from the UK, hearing positive stories gave participants hope and sustained them in their work with other unaccompanied children. This news seemed to more powerful because it was delivered on a random schedule and therefore enabled participants to endure numerous occasions that did not provide positive reinforcement.

'Sometimes in all the despair, it's nice for us to see some of the outcomes as well, it makes it more bearable' (3, 383-385)

Not 'letting children go' was thought to provide ways of avoiding possible guilt associated with ending contact. As participants feared ending contact would leave children alone and isolated and, also, replicate children's experiences of separation from their families. The intolerable nature of this fear and guilt may explain the powerful pressure and the lengths to which participants went to continue contact with children.

3.4 Managing positioning

The following section outlines participants' accounts of experiencing challenges in relation to conflicting ways they positioned themselves and were positioned by children with regard to the socio-political context of the therapeutic work. These positions created complex emotional responses that were described as challenging for participants to manage in their work. Participants used narratives of polarising positions to understand and manage their emotional responses, and also constructed accounts of working to search for a middle ground between these positions.

3.4.1 Conflicted positioning

3.4.1.1 Therapists positioning themselves

In talking about the impact of their work, participants described themselves seeing what 'really happens' (4, 919) to these children and constructed this knowledge as otherwise hidden from UK society. Having this knowledge caused participants to feel a sense of difference and distance from 'the rest of' society. They spoke of feeling less able to distance themselves from children's experiences and identifying themselves with children, rather than wider society.

'this is someone that I know, it's not someone that I'm reading about in the newspaper or saw on TV, this is someone that I've actually had a therapeutic relationship with...who has told me a whole range of pain and suffering related to where they're now being sent back to' (4, 681-685)

This seemed to create an 'us' and 'them' dichotomy, in which participants positioned children and themselves as 'us' and the rest of society as 'them'. Consequently, participants described feeling distant from people in their social networks who did not share their political views; positioning those who were sympathetic towards children as an 'us' and others who were perceived as unresponsive to their needs as a 'them'.

'my colleague...felt slightly disconnected...from her own social network, because they were coming from very different political ideas about refugees...That was quite important to me...to have people in my personal life who held similar views about...a sympathetic political response to these young people and...the right thing to do' (1, 176-191)

In response to perceptions of a lack of knowledge about children's experiences and a lack of sympathy towards their needs in wider society, participants described a range of emotional responses; including feeling a sense of injustice, frustration, and anger. These feelings were heightened in response to practices within the asylum system that participants viewed as especially 'unfair'; including dispersal to different areas of the UK, detention, deportation, and destitution. In the absence of knowledge about what 'really happens' to these children, participants spoke of fearing UK social structures will not change to better respond to their needs. As a result, they constructed social structures as 'insurmountable' and themselves as aggrieved, disillusioned, and powerless to make a difference.

'Feeling of 'there's no point', continued cycle of same thing happening over and over again to unaccompanied minors' (5, 171-172)

'I guess it sometimes feels like you are fighting a fight that can never be won...the wider systems that I get really frustrated with never seem to change, they just seem to get worse' (6, 597-603)

3.4.1.2 Children positioning therapists

Participants also gave accounts of being positioned by children, particularly when children compared their own temporary status in the UK to participants' permanent status. At these times, they experienced children identifying differences between them and positioning the participant with the rest of UK society. This created an alternative dichotomy in which unaccompanied children were an 'us' and therapists and UK society were a 'them'. This was captured by one participant's description of a child identifying them with decisions made by the UK government:

‘One young person said “why do they want to kill me?...if your government sends me back then they’ll be killing me, I don’t understand why they want to kill me” (4, 564-567)

Children identifying participants with decisions made by UK social structures was conceptualised as placing participants in a compromised position. Participants disagreed with ‘unfair’ practices, but were also working within the broader system and therefore described holding a sense of responsibility for the treatment of such children in the UK.

‘Working with a very unfair system...having to help them through bad experiences, where they’ve had a foster placement terminated with no notice or a solicitor who’s said “right your money is up, I can’t offer you anymore”...it feels very upsetting...and uncomfortable that we live in a country that does that to young people and doesn’t look after people properly...I find that very difficult’ (9, 152-162)

Participants described feeling guilty and uncomfortable with regard to their ‘privileged’ (4, 942) permanent status in the UK. Taken-for-granted assumptions in participants’ narratives seemed to give this guilt an intolerable quality. In conjunction with explicitly stating views that ‘refugee people are welcome’, their narratives were thought to indicate a values stance of hospitality, kindness, and generosity, particularly towards children constructed as young and vulnerable. This was considered to communicate an implicit protectionist values stance towards children; that children *should* have safety and stability, particularly those in living exile.

3.4.2 Polarising positions

Participants referenced the ‘drama triangle’ (Karpman, 1968) in relation to their emotional responses towards children and the socio-political context. The drama triangle conceptualises three positions that occur within narratives: the victim, the persecutor, and the rescuer. These polarised positions were used in participants’ accounts to structure their understandings of dynamics they experienced in their work and also to manage their complex emotional responses to children, their teams

and UK social structures. Participants' use of each of these three positions as narrative devices in accounts of their therapeutic work is expounded in the following sub-sections.

3.4.2.1 The 'rescuer' position

At times, participants constructed children as vulnerable and helpless, positioning them as 'victims' in relation to persecutory figures who were perceived as unresponsive towards children's needs; such as team managers, other professionals and services, UK social structures and society. In response, participants positioned themselves as rescuers and gave accounts of feeling as if they were 'the only one' who was 'fighting for' children and joining with them 'against the world' (6, 504).

'in relation to the young people we might have...the possibility of falling into a rescuer position, against maybe for example the home office...and all those people who were victimising these clients' (1, 236-239)

In relation to tensions experienced between boundaries and flexibility, this position seemed to overvalue flexibility at the expense of boundaries. When participants narrated themselves in a rescuing position, they described going beyond boundaries of therapy, doing too much, and making promises they could not keep. For instance, 'unconscious' promises that "I will save you" or "I will protect you" from perceived or actual persecution (6, 483). Transference relationships created in therapy seemed to also position participants in rescuer positions. For example, when they described wanting to take children home, parent them and therefore, perhaps, rescue them.

'I started working with him just before he became destitute...and I can remember the first time I met with him thinking "no that's not possible, we can do something about this" even if it meant us doing a piece of work that was normally beyond our realm...we all kind of went into overdrive...it had a big effect on me of just feeling angry and...totally powerless' (3, 315-339)

The development of trusting therapeutic relationships in which participants responded to the needs of children, who were otherwise isolated and powerless, could also be considered to invite 'idealisation' (8, 123) of therapists as rescuer figures. Participants' narratives emphasised their intentions to be helpful and supportive in responding to children's needs, but their limited power restricted their abilities to do so.

'there was always a point where, when we were working with those clients...we felt ourselves being pulled into trying to rescue them in some way, needing to just stop that because that has a really harmful effect in the sense that there is nothing that we can do, but sometimes it just feels like we need to try, but actually for those clients it's then just another disappointment' (3, 351-356)

The rescuer position was narrated as creating challenges regarding participants' limited power to respond to children's needs. Their accounts indicated a wish to be able to be more powerful. For example, to influence decisions regarding children's leave to remain in the UK:

'the challenges, well totally number one is managing wanting to rescue these young people, because of course you can't. You can write a court report but you can't force the Home Office to make a certain decision' (9, 144-146)

Implausible promises made to children were thought to indicate that this position gave participants an unrealistic sense of their power to meet children's needs. This perhaps served two functions. First, making participants feel powerful in situations where they might otherwise have felt powerless and frustrated, in order to enable them to continue on in their work. Second, enabling participants to feel as if they were doing as much as they could to meet children's needs; consequently relieving feelings of responsibility and guilt in relation to their compromised positions.

'I felt guilty and I felt angry that I was part of a country...that couldn't provide and wouldn't provide...I was on the one hand a representative of that...And on the other hand, wanting to make it clear that I wasn't part of that...that was a very difficult thing to resolve' (1, 475-481)

Taking up this position and feeling as if they were the 'only one' responding to children's needs was more likely to occur when participants felt isolated and were working without sufficient support from supervisors or other professionals and services. In the absence of this support, participants' sense of feeling compelled to respond to children's needs, put aside boundaries, and make unrealistic promises, was stronger. This perhaps indicated the power of the transference relationship for participants without time and space to reflect on dynamics in their therapeutic work with these children.

'if I feel something's got to me there's people I can talk to. Using supervision...I work very hard for those clients and I want to help them, but I know that they draw me in' (9, 181-184)

3.4.2.2 The 'persecutor' position

The rescuer position was constructed as precarious. Participants' narratives indicated that their positioning could quickly change from 'rescuer' to 'persecutor' in children's eyes. Rather than static, participants' accounts were consequently of feeling compelled and 'pulled' (3, 354) between different extremes, moving dynamically back and forth between the polarised positions of the drama triangle. Descriptions of children's distrust, suspicion, and rejection of therapy at the beginning of the work, as well as children identifying participants with the UK government, suggested participants had experienced children relating to them with as persecutory figures. When trust established in the therapeutic relationship was weakened, children were experienced as returning to relating to participants as persecutory figures. For example, when children felt as if they had been let down by unmet promises and expectations, participants' accounts suggested their position had moved from rescuing to denigrated persecutory figures.

'if you aren't able to maybe maintain a bit of distance, it can be quite easy to get sucked into the role that the young person wants you to play...once that ends...a young person might feel really sad or quite angry with you if there's been a real intensity and a relationship that has perhaps at times overstepped boundaries...one young person, I worked with him for nearly two

years...he was so angry with me...and a tutor helping me to think about, well maybe he expected so much from you that you couldn't give' (6, 526-562)

Participants' compromised position of working within a system with which they disagreed and their sense of responsibility towards the treatment of children in the UK created fears of being identified with a persecutor position. They were also constructed as fearing collusion with a persecutory system in relation to concerns regarding not using their power as fully as they might or withholding their time and energy. For instance, at times participants indicated fears of not doing enough in their work with children:

'I feel guilty quite a lot that I'm not doing enough...that feeling of never doing enough never goes away' (6, 617-619)

Being in a position of power in therapeutic work was therefore conceptualised as entailing intolerable guilt, due to fears of being identified or colluding with a persecutory position, which led to a subsequent move to less powerful rescuer and victim positions.

3.4.2.3 The 'victim' position

As well as positioning children as victims, participants' narratives identified themselves with this position in response to three scenarios. Firstly, children's powerful responses when they had been let down by unmet promises were thought to mirror constructions of the persecutor position, in relation to participants identifying with a helpless, victim position. This was captured by one participant's description of a child's anger when she had been unable to meet their expectations:

'one young person...I remember he came into my office one day and he was so angry with me I actually had to leave the room, I remember him kicking my chair and at the time I couldn't work out, after I left he kicked and kicked my chair' (6, 556-559)

Secondly, team managers were positioned as persecutory figures when they were constructed as rigid and withholding of resources. For example, when team

managers prioritised boundaries in therapeutic work and restricted the flexibility of participants' responses to children's needs.

'in the team sphere we often felt kind of victimised, say by the team managers or people who were in authority there, who would boundary the work in a way that we didn't feel was helpful' (1, 239-241)

Third, descriptions of UK social structures as 'insurmountable' and themselves as powerless to make a difference, perhaps positioned this system as persecutory and participants as helpless and aggrieved in their work. These accounts were thought to indicate participants identifying with children's positions as victimised, against persecutory systems. In response, they spoke of putting models of therapy aside to focus on the therapeutic relationship and 'join' with children's position, through validating the sense of being aggrieved by the persecutory system and acknowledging a lack of control. For example, that there was 'nothing that could be done'.

'we just spent time together and we just acknowledged how hard it was...I sort of had to put things into perspective...so what could I do for him? Because I could let him know that he mattered...And actually, when you've got nothing, that becomes quite important' (3, 345-352)

This was the opposite of the rescuer position, in which a central idea was that something 'had' to be done. Joining with the victim position may have been a further way of relieving guilt, by putting aside all power to identify with children's powerlessness. However, by putting their models of therapy and power aside, participants perhaps dispensed with the structure, skills and influence they did have to continue to be helpful to children; thereby moving from one extreme to another.

3.4.3 Searching for a middle ground

The polarised positions of the drama triangle were constructed as both helping and hindering participants to manage challenges arising in therapeutic work with unaccompanied children. Participants' narratives were therefore understood as indicating a search for a middle ground between these positions. The following sub-

sections examine conceptualisation of participants' search for ways of working that provided clarity and structure to guide their therapeutic work, as well as enabled them to work towards empowering children.

3.4.3.1 Seeking clarity

Participants' accounts constructed therapeutic work with unaccompanied children as complex and dynamic. Narratives of their experiences of therapeutic work were conceptualised as mirroring children's experiences of displacement. Their descriptions of meeting children 'where they are', balancing boundaries and managing conflicting positions were thought to indicate a sense of displacement from the familiar roles, models and concepts of conventional western therapy. The displacement was understood to create a lack of clarity with regard to their roles in work with these children. This is illustrated by participants' narratives of their roles as therapists, care-coordinators, social worker, as well as taking up positions as children's family members. In response to the complexities of the work, the polarised positions conceptualised by the drama triangle were considered to represent participants' attempts to seek a sense of clarity with regard to their role. For example, as a 'rescuer' participants' role was to 'fight' against persecutory systems or as a 'victim' their role was to join with children's powerlessness.

'it was very kind of polarised...that created a lot of tension but also was a way of understanding the kind of intensity of the feelings that were being engendered...it helped me to think myself out of those very polarised positions, which aren't helpful, and to think about the complexities of each kind of relationship' (1, 239-247)

The simplicity and structure of these positions perhaps enabled participants to find temporary ways of continuing in their work. However, the polarised nature of the positions was also unhelpful in terms of risking letting children down and creating unhelpful dynamics within teams. The oversimplified positions also created 'either/or', 'black and white', 'us and them' positions; masking the complexities of the work and the reality of working in grey areas, in-between these dichotomies.

3.4.3.2 Creating structure

In being displaced from their familiar roles, concepts, and models, participants demonstrated a loss of their sense of safety, control, and structure in their work. The extent of children's unmet needs, and the flexibility of responses to their needs in therapeutic work, meant that therapy was 'redefined' (2, 263) so much that at times there was little structure for participants to hold onto. Participants' accounts indicated that this created confusion regarding how to understand their endeavours within the therapeutic work.

'Working with these children makes you question what you're doing and ask "what am I doing? Is this therapy?"' (5, 50-51)

'sometimes I felt myself at a complete loss...And I thought "what am I doing here, am I doing therapy? I have no idea". So I can give you an account of what I tried to use but on the other hand, there's also frequently that feeling of "is this therapy? What am I doing? What am I calling therapy?"' (1, 570-580)

Adhering to familiar ways of working might have enabled participants to maintain a clear sense of their role and provided structure within the complexities of the work. However, rigid adherence to western approaches was associated with ethical dilemmas regarding responding to children's needs and perhaps fears of colluding with inflexible, unresponsive, persecutory systems. Instead, participants' narratives indicated a process of searching for a middle ground between rigidity and flexibility. This search seemed to entail holding onto conventional western therapy models and boundaries enough to provide structure for participants and be helpful to children, whilst also flexibly putting aside these models enough to be able to respond to children's needs. As one participant describes:

'Being flexible and adaptable, but to a point' (2, 352)

This process is described in participants' constructions of meeting children 'where they are' culturally by employing western models flexibly to search for a middle ground between their two cultures; rather than rigidly remaining within western culture or dispensing with western concepts completely to engage only with children's non-western culture. Narratives of meeting children's practical and

emotional needs concurrently also provided examples of participants searching for a middle ground. The two stage model was conceptualised as an attempt to create structure that not only held onto western models of therapy sufficiently, but also provided enough flexibility for participants to meet children's needs.

3.4.3.3 Working to empower children

In the middle ground, participants' positions were thought of as neither powerful nor powerless. Instead, the middle ground was constructed as overlapping the victim, persecutor, and rescuer position. Having little power enabled participants to identify with and relate to children in the victim position; similar to the persecutor position, they had enough power; but, as with the rescuer position, the power was used benevolently to help children. When participants positioned children as victims, their vulnerability seemed to be overemphasised. In taking up rescuer positions themselves, children were disempowered and participants spoke of doing too much for them. Searching for a middle ground between flexibility and boundaries seemed to be associated with working towards doing enough, but not doing too much. This is in contrast to the rescuer position in which participants described doing too much, and the unresponsive persecutor position that was constructed as not doing enough. In supporting children enough but not too much, participants constructed the aim of their work as to empower children.

'maybe work towards empowering someone more, rather than trying to play quite a mothering role' (6, 567-568)

'Unaccompanied children don't have a voice, it's important to get them heard, we need to use our position to empower them' (5, 169-177)

Participants spoke of using a number of strategies to help them find a middle ground between the polarised positions and maintain a focus on empowering children. Supervision, joint working with other professionals, and time for reflective practice were framed as important to enable participants to hold onto boundaries of therapy. Furthermore, as described in the following sub-sections, intervening to improve responses to children's needs more broadly within services and at a political level

were constructed as helpful ways of maintaining a middle ground position within therapeutic work. In contrast to the polarised positions of the drama triangle, these interventions were framed as enabling participants to resolve some of the guilt of their compromised position in ways that were not considered to hinder therapeutic work.

Intervening at a service level

As well as meeting children's needs in therapeutic work, participants also talked about responding to their needs by intervening with other professionals and services involved in supporting unaccompanied children. They identified three key issues impacting on the quality of services offered to children. Firstly, practical barriers to accessing services, for instance when children were unable to read addresses and use maps. Second, discrimination children sometimes experienced from professionals and services, such as exclusion from schools and the culture of disbelief meaning children's problems were not be taken seriously. Thirdly, a lack of understanding of children's needs and experiences preventing the provision of appropriate support. In response, participants gave accounts of working to build partnerships with other professionals and services to advocate for children and also increase their understandings of children's needs.

'we have to step in to explain that they didn't chose to come, they come because they want to live... every human being has a right to live...not to be murdered or to be tortured, not to be persecuted...constantly making people aware of that' (7, 340-344)

'The other thing is, we've done all sort of work in schools, inviting teachers into the endings of the group so that young people can talk about what they've done in the hope that it will sort of educate staff a bit more about their experiences and help staff to respond' (9, 200-206)

In relation to working with other professionals, participants spoke of working with large numbers of foster carers. This perhaps enabled them to find a middle ground

in terms of meeting children's needs for parental figures and homes indirectly through their foster carers, rather than taking on this role themselves.

'working with foster carers particularly because they're the ones providing the home and surrogate families for these young people. Social services, schools...contribute to the network, the team around the child...to enhance what other people are offering' (9, 210-215)

Intervening politically

Participants also gave accounts of working to respond to children's needs at a political level. Examples of these interventions were: promoting children's stories to increase awareness of their experiences in wider society, for example through conducting and participating in research; participants using their position as professionals to empower children's voices to be heard, such as by collaborating with documentary film makers; and, campaigning against discriminatory social policies.

'being involved in research...thinking about what needs to be further researched in the area is important. Looking for ways to make their voices heard...that has fuelled me in the work to promote their stories...thinking about how I can influence different levels' (2, 368-374)

'My experience as a practitioner is incredibly frustrating, anger-making, um makes me want to...write to all the MPs...pushed me to do more with the kind of political front because it's just plain wrong' (1, 151-155)

Participants portrayed their decisions to intervene politically as serving three functions. First, to work on behalf of children to improve responses to their needs. Second, to provide an 'outlet' for feelings of anger outside of therapy, instead of taking up rescuer positions in therapeutic work. Third, rather than connecting with feelings of disillusionment and powerlessness in therapy, these interventions were constructed as enabling participants to feel more hopeful and powerful with regard to making a difference to UK practices towards these children.

'That's my hopefulness again, connecting to the possibilities of things being better for these young people and being part of that is just amazing' (1, 1008-1010)

Chapter 4: Discussion

This chapter begins by summarising the analysis, before revisiting the research questions posed at the end of chapter 1 to consider the extent to which they are answered by the analysis. Comparisons of the analysis and existing literature are discussed. An evaluation of the research is offered, before suggesting areas for further research. Implications of the research for professional practice are then proposed. Finally, the chapter ends with the researcher's reflections on the study and concluding comments.

4.1 Summary of the analysis

The ultimate aim of the analysis was to develop a tentative grounded theory of participants' accounts of therapeutic work with unaccompanied refugee young people. A diagram was constructed to represent the grounded theory (see figure 3). The diagram conceptualises the characteristics of the polarised victim-rescuer-persecutor positions, which overlap 'searching for a middle ground'. The middle ground is held in tension between the opposing forces of the polarised positions, pulling participants simultaneously in opposite directions. In the middle ground, participants searched for ways to respond to children's needs by balancing the characteristics of the victim-rescuer-persecutor positions. Although the diagram appears static and neat, the therapeutic work is dynamic and complex, with participants occupying multiple positions simultaneously. Rather than being a 'place' or a 'destination', 'searching for a middle ground' is an on-going process of finding balance and momentary homeostasis in an ever-changing system.

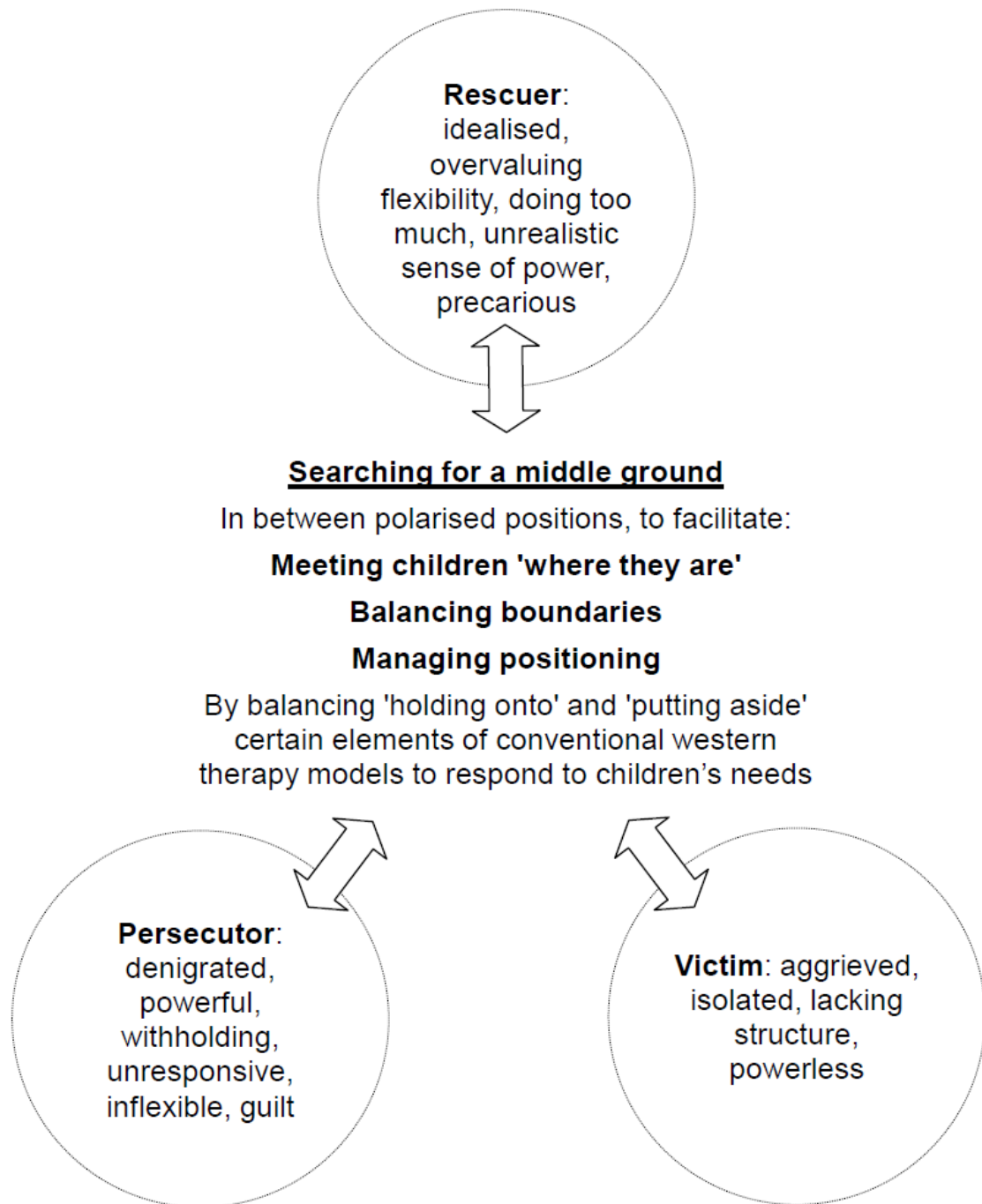


Figure 3: Diagrammatic representation of the grounded theory of participants' accounts of therapeutic work with unaccompanied refugee young people

4.2 Answering the research questions

Three research questions were developed to guide the construction of a theoretical understanding of therapists' accounts of therapeutic work with unaccompanied refugee young people. The following sections revisit these questions to discuss the extent to which the analysis provides answers for each question.

4.2.1 How do therapists experience their role in their work with unaccompanied refugee young people?

Significant in the analysis, with regard to the above research question, were participants' accounts of their role in therapeutic work with this group. In the analysis, the extent of unaccompanied children's needs was thought to displace participants from their familiar roles and create dilemmas regarding being a 'good' therapist and person. Consequently, participants were constructed as experiencing a lack of clarity in relation to their role. The use of polarising positions as narrative devices in participants' accounts was interpreted as an attempt to seek clarity about their role. Although helpful in providing clear roles, these positions were framed as over-simplified and creating unhelpful dynamics in therapeutic work. In response, searching for a middle ground was therefore conceptualised as a process of balancing helpful characteristics of the rescuer, persecutor, and victim positions to provide sufficient clarity in their roles without obscuring the complexity of therapeutic work with unaccompanied children.

4.2.2 How do therapists experience employing available models of therapy in their work with these children?

The analysis provided conceptualisations of the challenges participants described experiencing in employing conventional western models of therapy in their therapeutic work with unaccompanied children. Working with this group was thought to displace participants from their familiar models of therapy. The flexibility with which they responded to children's needs meant that at times therapy was 'redefined' to such an extent that participants experienced a loss of structure. The

polarising positions were understood to create extremes. For instance, associating maintaining a clear structure by rigidly holding onto western models of therapy with 'persecutory' systems, in contrast to losing a sense of structure by putting aside or going beyond therapy models in the victim and rescuer positions. Participants' narratives indicated a search for a middle ground between rigidity and flexibility in employing models of therapy. This involved holding onto therapy models enough to provide structure, whilst also flexibly putting aside these models to be able to sufficiently respond to children's needs. Narratives of meeting children 'where they are' culturally by employing western models flexibly, rather than rigidly remaining within western culture or dispensing with western concepts completely to engage only with children's non-western culture, were thought to be examples of searching for a middle ground. The two stages of therapeutic work constructed from participants' accounts were also considered to provide an example of creating a framework to guide the work, which balanced structure with flexibility. This enabled participants to employ therapy models in helpful ways and respond to children's changing needs over the course of the work.

4.2.3 How do therapists experience the social context of their work with this group?

Participants discussed their experiences of the social context of their work at a service level, as well as at a political level. At a service level, when children's needs beyond that of therapy were not supported by other professionals and services, participants experienced dilemmas in relation to maintaining their role whilst also feeling compelled to respond to children's needs. At a political level, participants gave accounts of the treatment of unaccompanied children in the UK and adapting their approach to respond to the emotional distress these experiences were perceived to create. Participants' narratives indicated experiences of conflicted and compromised positioning in relation to children and the socio-political context. These positions created emotional responses of anger, disillusionment, and guilt that were challenging to manage in therapeutic work. The polarising positions provided ways of relieving difficult emotions. Participants constructed the socio-political context of the UK as restrictive, unresponsive, and persecutory. In response, participants

constructed children as victims and themselves as either powerful rescuers or identified with children as powerless victims. Searching for a middle ground provided alternative ways of managing emotional responses outside of direct therapeutic work by intervening with other professionals, services, and politically to work towards improving responses to children's needs within the wider social context.

4.3 Comparing the analysis with existing literature

As recommended by Charmaz (2006), constant comparisons were used to locate, illuminate and evaluate the analysis within existing literature. The following section discusses the extent to which the findings of the study confirm, challenge and offer new insights in relation to previous research.

4.3.1 Meeting children 'where they are' culturally

4.3.1.1 Bicultural experiences

Participants described attempts to translate therapy across cultures as a disorienting experience. Offering insight that supports participants' accounts of sometimes irreconcilable conceptual frameworks, literature regarding comparisons of western and non-western cultures highlights considerable differences in social contexts and constructions (Guarnaccia & Lopez, 1998; Summerfield, 1995, 2000).

Unaccompanied children are thought to feel disoriented upon arriving in countries of asylum and caught between their loyalty to the culture of their home country and their wish to assimilate into the culture of the host country (Derulyn & Broekaert, 2008; Papadopoulos, 2002). Participants' descriptions of navigating familiar western and unfamiliar non-western concepts could be viewed as mirroring children's bicultural experiences; extending existing accounts of professionals emotional experiences reflecting those of unaccompanied children's (Free, 2003; Kohli, 2007; Melzak, 2009).

4.3.1.2 Increasing accessibility

Reviews of mental health service provision raise concerns regarding the requirement to accommodate children's cultural needs to make therapeutic work accessible (Brownlees & Finch, 2010; De Anstiss et al., 2009; Hodes, 1998; Thomas et al., 2004). Participants of the present study discussed strategies to respond to children's needs, including not making assumptions about children's understandings, and, instead, making therapy practices explicit and developing shared understandings. Although complex, uncertain and time-consuming, these strategies offered valuable ways of increasing the cultural and conceptual accessibility of therapy for this group.

4.3.1.3 Employing therapy models flexibly

Participants in this study consistently emphasised the importance of flexibly selecting and adapting therapy models in order to fit therapeutic approaches around children's cultural, emotional and practical needs. The practice of incorporating different models of therapy to respond flexibly to refugee children's needs is also described by Melzak (2009), Stedman (2003) and Warr (2010), who integrate psychodynamic, systemic, and narrative approaches in their therapeutic work. In comparison, limited effectiveness of adhering to rigid structures and single models of therapy in work with this group can be seen in research regarding a manualised CBT group for refugee children (Ehnholt et al., 2005).

4.3.1.4 Using the concept of PTSD

Existing research regarding the concepts of trauma and PTSD is largely split between unquestioning assumptions of their usefulness and critiques of their harmful consequences. Participants' narratives suggested an alternative 'middle ground' position between polarised debates. This entailed employing western models of therapy flexibly, to both hold onto helpful elements of these concepts for unaccompanied children and minimise unhelpful consequences. In accordance with

Summerfield (2000), searching for this middle ground involved not taking-for-granted western assumptions of a universal need to work through trauma memories for recovery. To go against this assumption, the present study found that participants often felt required to deconstruct dominant narratives within the NHS, NICE guidelines about what therapists 'should' do, and constructions of 'good' therapists.

4.3.1.5 Therapists' roles

Groark et al (2010) propose key roles for therapists working with unaccompanied children are: firstly, to support children to manage symptoms of distress; and secondly, to enable them to make sense of past trauma. Supporting children to manage the distress of their living situations in the UK was constructed as necessary for children to cope in the present study. However, doing so created tensions, ethical and moral dilemmas, placed participants in compromised positions, and created feelings of guilt. This perhaps reflected concerns about adjusting children to unjust practices and societies, rather than adjusting societies to respond more equitably to children's needs (Summerfield, 2000). Extending existing research regarding therapists' roles, the findings of the present study suggest a further key role for therapists is to use their position, power and understandings of unaccompanied children's experiences to intervene politically and advocate for better responses to children's needs.

4.3.2 Meeting children 'where they are' emotionally

4.3.2.1 Going against the culture of disbelief

Adopting a non-neutral stance was considered important in offering therapeutic experiences to counter children's experiences of the culture of disbelief.

Psychoanalytic literature describes two attitudes towards clients' views of reality: 'classic' and 'romantic' (Lemma, 2010). The classic approach takes a sceptical stance towards clients' perceptions of reality. Comparisons with findings of the present study suggest this approach risks invalidating children's experiences and

replicating the scepticism they experience in the UK. Participants' descriptions of 'going against the culture of disbelief' were thought to fit with the romantic approach. This entails therapists enhancing the validity of clients' perceptions through 'emphatic affirmation' and 'explicit warmth' (Lemma, 2010, p.420). Although this approach is therapeutically valuable for children, the romantic attitude risks therapists unduly identifying with clients' views (Lemma, 2010). As described in the present study, therapists are perhaps required to balance taking a non-neutral stance towards unaccompanied children's experiences with a 'pull' towards identifying with rescuer and victim positions.

4.3.2.2 Fostering a sense of agency

Giving children control was a distinct feature of participants' accounts of their approach to therapeutic work. Young people who have endured 'traumatic' experiences are understood to have a heightened need to feel powerful and in control (Lemma, 2010). For unaccompanied children who have not only experienced past 'trauma' but also have little control over their future, the need for control may be even stronger. Blackwell and Melzak (2000) suggest creating a sense of agency can counterbalance the helplessness unaccompanied children experience in the socio-political context of the UK. Searching for a middle ground between disempowering 'rescuing' dynamics is therefore a crucial process to make it possible for therapists, and other professionals, to foster a sense of agency and offer unaccompanied children empowering experiences.

4.3.2.3 The power of 'being there'

'Being there' was constructed as essential to enable participants to provide a positive attachment and secure base for unaccompanied children. Lemma's (2010) study of therapeutic key-working at Kids Company, an organisation offering support to young people who have had 'traumatic' experiences, provides helpful findings to further conceptualise the therapeutic value of this process. In her study, reliably and consistently 'being there' was considered important in providing a 'qualitatively

different emotional experience' for young people and creating a new object relationship that 'understands, anticipates, contains and meets' their needs (Lemma, 2010, p.418). Not only are attachment relationships theorised to act as buffers against unaccompanied children's present experiences (Kia-Keating & Ellis, 2007), but Lemma argues their value continues on into young people's futures.

Young people internalising their experiences of key-workers containing their distressing emotions was regarded as enhancing their ability to self-contain their emotions (Lemma, 2010). This process was thought to make it possible for young people to move away from the secure base developed within the relationship; as they were understood to have internalised a secure base in their minds that they could access when needed. These relationships were believed to be transformative in changing young people's lives. The most important role of key-workers working with 'traumatised' young people was therefore conceptualised as 'the power of relationship'. (Lemma, 2010, p.409). In contrast to participants' accounts of taking up multiple roles and searching for clarity around their role in the present study, Lemma's research suggests that perhaps participants' most crucial role was in the trusting, therapeutic relationships they established with unaccompanied children. This connects to participants' descriptions of the essential need to 'be there' for children and focus on the fundamental therapy skills of listening and 'bearing witness', as well as their warning against moving on to 'secondary' therapeutic techniques before this secure attachment was firmly established.

On average, only 11% of unaccompanied children are granted indefinite leave to remain in the UK each year (Kohli, 2011). The majority of children participants worked with were therefore likely to have been deported. Descriptions of anger, frustration, and disillusionment within the present study are reflected in research with social workers and have been associated with a sense of feeling as if hard work with these children had been undone (Kohl, 2007). Findings of the present study highlighted fears of colluding with persecutory systems. This fear possibly silenced expressions of hope that participants' hard work may be maintained through the internalisation of secure and containing objects within unaccompanied children's internal worlds. Maybe explicitly sharing this view could have felt as if it risked colluding with the persecutory systems that condone and conduct practices of

deporting unaccompanied children. Positive views of the therapeutic value of 'being there' might, however, offer some hope in the otherwise hopelessness and awfulness of unaccompanied children's situation.

4.3.2.4 Having a sense of home

Papadopoulos (2002) proposes that an experience common to all refugee people is a loss of home. In the present study participants gave accounts of wanting to provide a physical home for unaccompanied children and instead internalising children to take them home metaphorically. Papadopoulos' observation suggests this process may have occurred as a counter-transference derived from children's search for a sense of home. Papadopoulos (2002) describes the idea of 'home' as not only a concrete physical house, but also a space combining psychological processes basic to emotional development. Drawing on Papadopoulos' idea, Kohli (2011) suggests unaccompanied children may experience a metaphorical 'home' in key relationships with others. Rather than providing a literal home, this indicates therapists may provide a symbolic home for children within the therapeutic relationship.

Papadopoulos (2002, p.16) also describes home as a place that contains irreconcilable opposites; encompassing 'distance and proximity...hopes and disappointments, flexibility and obstinacy...similarities and differences, to name but a few'. Unaccompanied children's loss of home was hypothesised to entail a loss of containment of these opposites, which was thought to be mirrored in participants' accounts. Without their familiar western models of therapy and a sense of clarity regarding their role, participants could be viewed as having lost their sense of 'home' and containment in their therapeutic work. The loss of structure described in the present study might have also resulted in a lack of containment, which perhaps contributed to the enactment of dichotomies and polarising positions.

4.3.3 Meeting children ‘where they are’ practically

4.3.3.1 Practical tasks as therapeutic interventions

Participants framed supporting children with practical tasks as an important feature of their therapeutic work. The present study and existing literature converge to construct doing practical tasks as a valuable therapeutic intervention for unaccompanied children. Firstly, practical tasks were considered to be of value in demonstrating participants’ flexibility, in response to the complexities of children’s living situations. Young people with experiences of ‘trauma’ have been found to consider formal psychotherapy to be ‘too rigid and unresponsive’ to their unpredictable needs (Lemma, 2010, p.7). Similarly, Papadopoulos (2002) argues that formal psychotherapy may not be appropriate for all refugee people. Comparable to participants’ descriptions of their work in the present study, ‘therapeutic care’ is put forward as an adjusted application of psychotherapeutic principles to any assistance offered to refugee people, including the provision of practical support (Papadopoulos, 2002).

Secondly, participants gave accounts of practical tasks facilitating trust and relationship building. Lemma (2010) offers additional conceptualisations of practical tasks as concrete gestures of support that act as a bridge for fostering trust before young people begin to trust less tangible forms of emotional support. Contrasting the power imbalance ingrained in patient-therapist relationships in formal psychotherapy, Lemma (2010) suggests the informality engendered in offering practical support creates a level playing field between professionals and young people. In relation to the present study, this research extends findings by proposing that practical tasks are of therapeutic value in reducing the power imbalance between therapists and children. Power was constructed as closely associated with a persecutory position. Reducing power imbalances in therapy with these children could therefore also have implications for enhancing their sense of safety in the therapeutic relationship.

4.3.3.2 Titrating intimacy

Therapeutic work with unaccompanied children was constructed as involving two distinct stages. Comparisons with Lemma's (2010) phased model of key-working interventions offer further insights into processes occurring in the first stage of therapy with unaccompanied children. Closeness is understood to be experienced as risky by 'traumatised' young people, in terms of the vulnerability associated with intimacy. In her study, Lemma (2010) consequently noticed key-workers facilitating a process of 'titrating intimacy' through offering practical support and engaging in informal interactions. Less formal spaces, such as cafes and parks, were observed to provide opportunities for informal therapeutic conversations that facilitated young people gradually 'opening-up'. Alongside practical support, these conversations were considered to create a 'concrete' bridge to trusting and stable attachment relationships with young people (Lemma, 2010).

In relation to the findings of the present study, participants' narratives of 'moving from the practical to the emotional' could be understood as allowing children to titrate intimacy by conceptualising practical tasks as offering a way of maintaining a 'safe enough distance' at the beginning of therapy (Lemma, 2010, p.414). Whereas key-workers in Lemma's (2010) study had no therapy training, the present study extends existing literature by offering suggestions regarding therapeutic skills considered helpful at different stages of therapeutic work; with regard to primary skills fundamental to relationship building and secondary skills providing tools for supporting children with specific mental health needs.

4.3.4 Balancing boundaries

Participants described experiencing difficulties with team managers who restricted the duration of therapeutic work, as well as challenges 'letting go' of children. Melzak (2009) validates these experiences by arguing that the focus on short-term treatments and preoccupation with treating symptoms of 'disorders' in the NHS can run contrary to unaccompanied children's needs. Short-term treatments are thought to overshadow unaccompanied children's need for long-term secure attachment figures and therapeutic relationships (Melzak, 2009). Furthermore, research

regarding unaccompanied children's wellbeing emphasises the need for long-term support to help them maintain their wellbeing over the course of numerous distressing events in the UK (Chase et al., 2008). This research and findings of the present study raise questions regarding protocols for the duration of therapeutic work with these children. Perhaps open drop-in groups, as suggested by two participants in the study, might be a useful way of supporting children to maintain their wellbeing that could also fit with NHS requirements to utilise resources sparingly; although consideration may need to be given to therapists' reasons for maintaining contact. It is clear from the present study that hearing children's positive news sustained participants in their work; however, the irregular nature of this positive reinforcement may mean that alternative forms of support may also be necessary to enable therapists to keep going in their work.

4.3.5 Managing positioning

4.3.5.1 Managing distance

Kohli (2006) describes three positions in social work with unaccompanied children, which could be compared to processes constructed in therapeutic work in the present study. 'Humanitarian', 'witness' and 'confederate' positions (see section 1.5.2.2) were conceptualised to represent social workers: retreating to distance themselves from distressing emotions; or, blurring boundaries in their relationships with unaccompanied children to lessen distance and provide additional emotional support. These dynamics share similarities with Byng-Hall's (1988) discussion of challenges maintaining appropriate emotional distance in therapeutic work. This research and the present study were thought to support findings of participants alternating between being 'too close' in rescuer and victim positions or 'too far', as associated with a persecutor position. 'Searching for a middle ground' may therefore offer professionals a way of working towards balancing being close enough to unaccompanied children, whilst also maintaining a 'safe enough distance' (Lemma, 2010). The present study highlights that at this distance, participants were able to respond to children's needs whilst also meet their own needs in order to sustain themselves in their therapeutic work.

4.3.5.2 Mirroring marginalisation

Simmonds (2004, p.74) writes that therapists working with unaccompanied children may experience similar marginalisation as these children and suggests they may find themselves in an 'in-between space', without group membership as a basis of their legitimacy. This idea offers an interesting perspective on the findings of the present study. Constructions of 'grey areas' within the complexities of the therapeutic work and the socio-political context could be framed as participants working in 'in-between spaces', mirroring the space children occupy in UK society. Narratives of conflicted and compromised positioning could be understood as participants finding themselves without group membership, as neither an 'us' nor a 'them'. The process of going beyond conventional models of therapy could be viewed as positioning participants on the margins of 'traditional therapy'. Simmonds proposes that group membership provides a basis for legitimacy. This perhaps contributed to participants questioning their legitimacy as therapists and, in response, working to resolve dilemmas of being a 'good' therapist in order to validate the 'legitimacy' of their group membership.

4.3.5.3 Replicating dominant discourses

Findings of the present study highlighted polarising positions that hindered therapy by oversimplifying and obscuring the complexities of the work. Polarised and oversimplified positions can also be seen in the literature. For example, the polarised vulnerability/resilience debate in research that constructs unaccompanied children as having 'tragic identities' in contrast to 'inherently resilient' (Evans, 2008; Kohli & Mitchell, 2007). Papadopoulos (2002, p.28-29) argues that the concept of trauma and the refugee-trauma discourse 'tends to polarise positions and reduce complexities to simplistic formulae'. Viewed in the context of existing literature, the use of polarised positions in the present study could be seen as reflecting and implicitly drawing on narrative devices employed more widely within dominant western discourses.

In the present study, participants taking up rescuer positions was associated with constructions of children as vulnerable 'victims'. Papadopoulos (2002) applies the

refugee-trauma discourse to dynamics within the drama triangle to argue that pathologising constructions of refugee people frame them as victims. In therapy, he proposes that these discourses result in victim-rescuer dynamics being easily generated between refugee people and therapists. Narratives of victim-rescuer dynamics within the present study could therefore be understood as implicitly replicating pathologising dominant western discourses regarding refugee people and constructions of the vulnerability of unaccompanied children.

4.3.5.4 Impact of service provision

Participants described feelings of frustration towards a lack of services and inadequate responses of existing services to unaccompanied children's needs. These concerns are reflected in reviews of the responses of UK services to unaccompanied children's needs (e.g. Ayotte & Williamson, 2001; Stone, 2000). Existing research highlights the impact of inadequate service provision on children's wellbeing (e.g. Groark et al., 2010). The present study also highlights the impact this has on therapists working with unaccompanied children. The inadequate responses of services to unaccompanied children's needs were found to intensify participants' feelings of responsibility and guilt, as well as create challenges to boundaries in therapeutic work. Papadopoulos (2001, p.8) describes services being positioned as persecutors figures when refugee people are not offered the kinds of support that therapists expect and demand for them. Existing literature and findings of the present study also indicate the impact of inadequate service provision on dynamics between professionals and services, with participants taking up rescuer positions when other professionals and services were experienced as unresponsive and 'persecutory' towards unaccompanied children.

4.3.5.5 Improving services' responses

Chase et al (2008) suggest that a lack of training in understanding and identifying unaccompanied children's needs may be causal in the inadequate responses of professionals and services to the needs of this group. In the present study, this fits

with participants' interventions to improve responses of services as a constructive way of responding to their frustrations. In her discussion of the need for indirect therapeutic work with significant adults in unaccompanied children's lives to support them to best meet children's needs, Melzak (2009) emphasises the value of therapists' roles in training other professionals and services. In the Well Being Project, Austen et al (2008) also describes offering training and consultation to primary care staff to support them to identify unaccompanied children's mental health needs. The existing research and findings of the present study therefore indicate that therapists' roles in staff consultation and training perhaps make the profession well-placed to increase understanding and therefore improve services' responses to unaccompanied children's needs.

4.3.6 Summary

Participants in the present study gave accounts of their experiences of the complexities of responding to children's cultural, emotional, and practical needs, as well as managing their own emotional responses to the therapeutic work in the context of a challenging socio-political context. It was clear from the research that the participants were thoughtful and active in their desire to do their best to respond to unaccompanied children's needs. Supervision and working with multidisciplinary team members, as well as other professionals and services was found to be important to support unaccompanied children's needs, as well as enable participants to hold onto their roles, skills, and maintain helpful positions in the therapeutic work. The challenges therapists face in therapy could be thought of as mirroring those faced by children themselves, and are consequently multiple, constantly changing, and not easily resolvable.

4.4 Evaluation of the research

The research was evaluated according to Charmaz's (2005) criteria for social constructionist grounded theory studies. The criteria is aimed at evaluating products of grounded theory research, however grounded theory is both a methodology and a

product. Additional evaluations were therefore included regarding the epistemological position of the study and respondent validation.

4.4.1 Evaluation of the grounded theory

The following sub-sections evaluate the quality of the theoretical understanding constructed in the present research in relation to Charmaz's (2005) evaluative criteria.

4.4.1.1 Credibility

According to Charmaz (2005), 'credibility' is achieved through intimate familiarity with the topic, gathering sufficient data to merit researcher's claims, making systematic comparisons between observations and categories, ensuring strong logical links between researcher's argument and analysis, and providing evidence for claims to allow readers to form independent assessments. In the present study, 'credibility' was achieved through three strategies. First, intimate familiarity with the topic was gained through developing sensitising concepts at the beginning of the research; reviewing the literature both before data collection and, more substantially, after constructing the analysis; reading and re-reading transcripts of interviews; as well as through generating three interim analyses prior to constructing the grounded theory. Second, the substantial experience of the nine participants and the in-depth method of generating data were thought to contribute to the theoretical sufficiency of the study. Third, the construction of logical links between analytical arguments and the analysis was ensured through simultaneously employing memo-writing and constant comparisons. Examples of data that seemed to fit with analytic ideas, as well as negative cases and exceptions that challenged ideas, were explored in memo-writing. Evidence of researcher's claims was provided through presenting quotes of extracts from transcripts to illuminate conceptual linkages with the data and allow readers to develop their own assessments of claims made within the study.

4.4.1.2 Originality

Charmaz (2005) refers to 'originality' in terms of exploring how the work challenges, extends and offers new insights to current ideas, as well as establishing the social and theoretical significance of the work. Ways in which the current research challenges and extends current ideas have been discussed through comparisons of the analysis with existing literature. The social and theoretical significance of the study has been established through reviewing existing literature and highlighting the paucity of research regarding therapeutic work with unaccompanied refugee young people.

4.4.1.3 Resonance

'Resonance' encompasses portraying the fullness of the studied experience, revealing taken-for-granted meanings, drawing links between individual lives and larger collectivities, and offering deeper insights to members of the studied group about their lives and worlds. By exploring participants' accounts of therapeutic work at different stages and in relation to multiple levels of context, the present study portrays the depth, complexity and range of their experiences. The researcher has sought to reveal taken-for-granted meanings in the data and constructions within the analysis, as well as contextualise the data within the socio-political context of the UK. This was in order to offer novel conceptualisations and an alternative perspective on processes that may occur in therapeutic work with unaccompanied children.

4.4.1.4 Usefulness

Charmaz (2005) defines 'usefulness' of research in relation to offering interpretations people can use in their everyday worlds, speaking to generic processes, sparking further research in other areas, and contributing to knowledge to make a better society. By grounding the construction of the analysis in participants' accounts, the analysis and comparisons of findings with existing literature are applicable to people's everyday worlds and useful to others working in

this area. With respect to transferability, the findings may have implications for work with unaccompanied children beyond therapy, to that of other professions, such as social work, psychiatry, case-coordination and support work; and also relate to therapeutic work with other client groups who may be perceived to share similar characteristics or circumstances, including accompanied refugee children and looked after children.

4.4.2 Epistemological position

The following sub-section addresses the extent to which the current research was faithful to the critical realist social constructionist epistemological position of the study. Firstly, in relation to the critical realist position, the research aimed to explicate the material reality of unaccompanied children's living situations and participants' therapeutic work, as well as the impact of the availability of material resources on participants' accounts of their experiences. The findings reflect children's experiences of loss, distressing encounters and difficulties regarding their living situations, such as their practical needs. For participants, the research remained close to the multiple contexts of therapeutic work; including the limited resources available within NHS and Local Authority services and the broader socio-political context, as well as the influence of these contexts on their experiences.

Secondly, with regard to the social constructionist position, the study intended to reveal taken-for-granted meanings and examine the impact of western cultural constructs on children, participants, and therapeutic work. For example western constructs of 'attachment', the 'self' and 'identity', as well as ways in which participants defined themselves as 'good' therapists and 'good' people. Willig (2008) argues that a limitation of social constructionist grounded theory approach is that it should theorise the role of the construction and use of language. However, this would mean engaging with the notion of 'discourse', which would transform the method into discourse analysis rather than grounded theory. The researcher was aware of the balance between the two approaches; rather than imposed on the analysis, discussions of 'discourses' were grounded in participants' narratives of their experiences of dominant discourses in the social contexts of their work.

4.4.3 Respondent validation

A further limitation of the study is that respondent validation was not obtained. Time constraints meant that participants were not sent copies of the analysis before the thesis was submitted. However, corroboration of the findings was achieved through sharing thoughts and ideas regarding the constructed codes and categories with my thesis supervisor, who has considerable experience of processes that occur within therapeutic work. The analysis and grounded theory of the research will be shared with participants following submission. Furthermore, participants' feedback will be useful in writing up the study for publication.

4.5 Implications for further research

The findings and limitations of the present study point to a number of areas for further research. Firstly, research could be carried out to further explore the findings of the present study:

1. It would be interesting to conduct focus groups with larger numbers of therapists to invite their feedback on the grounded theory developed in the present study through discussions of their experiences, reflections and ideas;
2. Research could also be conducted to further develop particular elements of the grounded theory. The findings of the present study and comparisons with existing literature indicated that therapists have a key role in using their position to advocate for adjusting society to respond more equitably to children's needs, rather than adjusting children to unjust practices and societies. Participants' accounts offered a number of strategies for intervening politically to improve responses to children's needs. However, the importance of this role perhaps merits further research to develop a richer understanding of available strategies for therapists to employ within this role.

Secondly, research could be conducted with therapists who have characteristics not represented in the current findings:

1. The participants of the present study were all female. It would therefore be interesting to interview male therapists to explore gender differences, for instance with regard to western constructions of masculinity and fatherhood, and whether these constructs impact on narratives and dynamics that arise in therapy with unaccompanied children.
2. For participants' in the present study, transference relationships with unaccompanied children may have become embedded due to the large numbers of children they had worked with. This may have consequently intensified dynamics occurring within the work. Exploring experiences of therapists who have worked with smaller numbers of unaccompanied children may therefore offer alternative perspectives and interesting comparisons.
3. Furthermore, an area not researched in the present study is that of the perceptions of therapists who have not worked with unaccompanied children. A review of existing literature highlighted that therapists may be reluctant to begin working with these children (Brownlees & Finch, 2010). Research along these lines could therefore offer insights into therapists' attitudes towards and concerns about working with this group.

4.6 Implications for professional practice

In light of the evaluation and recommendations for further research, a number of implications of the present study have been developed for practice with unaccompanied refugee young people:

1. Practices within therapeutic work should be made explicit to unaccompanied children to reduce the 'bewildering' nature of mental health services and make them more culturally accessible to this group.
2. Employing models of therapy flexibly offers a way of ensuring therapeutic work is appropriate for unaccompanied children's needs.
3. Practical tasks offer valuable therapeutic interventions for unaccompanied children as a way of titrating intimacy whilst building trusting therapeutic relationships, which can then pave the way for more emotion-focused work.

4. It is important to fostering a sense of agency in therapeutic work and work towards empowering unaccompanied children.
5. Dispensing with 'neutrality' may be a helpful way of going against the culture of disbelief in therapeutic work with unaccompanied children.
6. Supervision for therapists working with unaccompanied children might helpfully incorporate reflections on their experiences of their role, the need to balance flexibility with boundaries in their therapeutic approaches, the constant movement between positions represented in the drama triangle, and the socio-political context of the therapeutic work. This may support them to manage complex emotional responses and facilitate the ongoing search for a middle ground between polarising positions. Supervision may also be essential to explicitly consider ending the therapeutic work, due to the replication of separation and loss that endings may represent for the child, and the guilt and powerless emotions that may occur within the therapist.
7. Unaccompanied children may be dispersed to areas of the UK without experience and skills in working with this group (Chase et al., 2008). To reduce these children's experiences of a postcode lottery (Bhabha & Finch, 2006), therapists experienced in working with unaccompanied children may have an important role in training other therapists to establish better consistency in therapeutic work across services.
8. Therapists' roles in staff consultation and training make the profession well-placed to increase other professionals' understandings of unaccompanied children's needs and therefore improve the quality of service provision for this group.
9. Therapists have important roles in advocating for better responses to unaccompanied children's needs within society and could use their first-hand knowledge to better inform legislation and decision making at all levels of society.

4.7 Reflections on the research

The following section discusses my reflections of the influence of my position and interests on the research process, in relation to my theoretical biases and

assumptions. Henwood and Pidgeon (1997) recommend documenting each phase of the research to increase reflexivity. Further reflections on the research process from my reflexive diary are therefore presented in appendix 13.

4.7.2 Reflections on data collection

With regard to Charmaz's (2006) emphasis on researchers' sensitivity towards how they are perceived by participants, it was important to consider how participants' perceptions of my position during the interviews influenced their constructions of their accounts. As a 'trainee', participants might have been more likely to construct their accounts in accordance with perceptions of the 'right' thing to do, restricting the openness and richness of the data. With this in mind, I was transparent in explaining the position from which I asked questions. For example, when asking about 'boundaries', I was aware of dominant discourses about their implementation in western therapy. I was therefore careful to explain that my questions came from a position of curiosity, that I had not yet formed set opinions of how boundaries 'should' be implemented and was interested in participants' experiences of this issue. In doing so, I aimed to minimise misinterpretations of my intentions and invite more open reflections on these issues.

4.7.2 Reflections on data analysis

In relation to my interests, when deciding the focus of the present study, the situation of unaccompanied children sparked my curiosity with regard to the challenges of their experiences. As a researcher, I was aware that the emotive nature of the children's circumstances meant that at times I experienced 'vicarious engagement' with the topic. At these times I noticed myself slipping into realism and away from the critical realist social constructionist epistemological position of the study. At these times, I experienced difficulties identifying assumptions in the data, for example in relation to an implicit protectionist values stance towards children, as I too had taken this for granted. In contrast, as the data analysis continued I found myself becoming somewhat desensitised to children's experiences and experiencing

periods of emotional detachment from the research. At these times, I found it easier to identify my own and participants' assumptions. However, I noticed that this was at the expense of attending to the emotional qualities of participants' experiences.

With regard to the impact of my clinical experiences on the research, at the time of analysing the data I was on placement in a Community Psychology project for socio-economically deprived young people. I was mindful of how my work influenced my interpretations of the data. For example, after conducting 'street therapy' with young people on placement I was aware of the emphasis I placed on participants' narratives of 'mobile conversations' and the similarities between these two ways of working. At these times I was careful to question my interpretations and ensure my analytical ideas were grounded in the data by reading and re-reading my transcripts to look for alternative constructions.

As a trainee clinical psychologist developing my skills as a therapist, I also considered how my position influenced my interpretations of the usefulness of therapy for this group. In reviewing the literature on this topic, I was cognisant that existing research raises questions regarding whether therapy is, or is not, helpful for these children. At times, I was aware of tensions between questioning the value of therapy, whilst also maintaining a respectful stance towards participants of the study who clearly demonstrated their belief in the value of therapeutic work. As someone who is training in this role, I was also conscious of my investment in constructing therapy as helpful. Consequently the research does not answer questions about the 'rightness' of therapy for unaccompanied children, but rather offers accounts of processes occurring in therapeutic work within a challenging socio-political context.

4.8 Concluding comments

To summarise the thesis, this study has succeeded in providing some answers to questions about therapeutic work with unaccompanied refugee young people. Frequently, however, research does not provide answers but rather better questions. In keeping with the grounded theory approach, I would like to ground the end of the thesis in the words of one of the participants of the study, about her advice to therapists working with unaccompanied refugee young people:

'Patsie: I'm wondering, because I'm hoping that this research will be shared with people working in the area, is there any anything that you'd want to say in hindsight about your experiences to people working or wanting to go into the area?

T: Um, I guess if I was advising myself, if I was starting out again, there is something about this that is largely a personal and human endeavour and don't be afraid to jump into that. I think I got caught up for a long time with..."is this therapy?" but just trust that this is what's needed...Is this helpful to the person? Is this generally within the confines? Then yeah that's fine. So I guess that I would say that...and just that it was enormously, enormously satisfying work; really, really, really satisfying work, despite its frustrations and despite all the challenges...enormously satisfying, especially when...there's something about the youth and the possibility inherent in being fifteen, sixteen, seventeen' (1, 989-1007)

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Appendices

Appendix 1: Ethical approval letter

Below is a copy of the ethical approval letter from the University of East London Ethics Committee.

SCHOOL OF PSYCHOLOGY
Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.
uel.ac.uk/psychology

UEL
University of
East London

Doctoral Degree in Clinical Psychology
Direct Fax: 0208 223 4967

June 2011

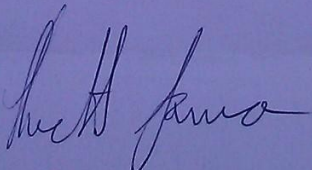
Name of Student	Patsie Staite
Title of Research Project	An exploration of therapeutic work with unaccompanied refugee young people

To Whom It May Concern:

This is to confirm that the above named student is conducting research as part of the requirements for the Professional Doctorate in Clinical Psychology. The Ethics Committee of the School of Psychology, University of East London has approved their proposal and they are, therefore, covered by the University's indemnity insurance policy. . This policy should normally cover for any untoward event provided that the experimental programme has been approved by the Ethics Committee prior to its commencement. The University does not offer "no fault" cover, so in the event of untoward event leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the above named is a student of UEL the University will act as the sponsor of their research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,



Kenneth Gannon PhD
Research Director

Appendix 2: Standard email sent to potential participants

Dear [potential participant],

I am a Trainee Clinical Psychologist studying at the University of East London. I am currently completing a research study for my thesis in which I am interviewing people working therapeutically with unaccompanied refugee young people about their experiences of their work and the challenges they face. I wondered if yourself or anyone you know of who is working therapeutically with unaccompanied refugee children might be interested in talking confidentially about their experiences.

I have attached some information about the study to this email. I can be contacted by email (XXX) or by phone (XXX) to discuss the study and participation. The research interview lasts about an hour and would need to be face-to-face so that I can record and transcribe the discussion for analysis. I am able to visit participants where they work or arrange an alternative location if this would be better. I am available on [days of the week].

Thank you so much for taking the time to read this email.

Many thanks and best wishes,

Patsie Staite

Trainee Clinical Psychologist,

University of East London

Appendix 3: Information sheet for potential participants

‘An exploration of therapists’ experiences of therapeutic work with unaccompanied
refugee young people’

Patsie Staite - Trainee Clinical Psychologist

School of Psychology, University of East London

My name is Patsie Staite and I am a Trainee Clinical Psychologist. As part of my training I am doing a study looking at therapists’ experiences of therapeutic work with unaccompanied refugee young people. I would like to ask for your help.

What is the study about?

The study is about the experiences of therapists working with unaccompanied refugee young people in the UK. I will be inviting therapists who work with these young people to participate in this study to explore their experiences of therapeutic work, including the challenges that they face, in order to help people working in services that come into contact with unaccompanied refugee young people.

Why is this study being done?

Reviews of the support that unaccompanied refugee young people receive in the UK have highlighted a need for improved provision of mental health services. There is currently little research specific to therapeutic work with unaccompanied refugee young people. Existing literature suggests there may be a number of challenges in working therapeutically with unaccompanied refugee young people, which raises questions regarding therapists’ experiences of their work, the challenges they may face and the ways in which these challenges are responded to. It is hoped that exploring therapists’ experiences of their work with unaccompanied refugee young people will widen the knowledge base that informs psychological theory and practice

with these young people, in order to inform improvements in the provision of mental health services to this population.

What will it involve?

I would like to meet therapists, like yourself, to discuss your experiences of therapeutic work you have engaged in with unaccompanied refugee young people. The research interview should take approximately 1 hour and I would like to audio-record the interview. I will ensure that the content of the interview will remain confidential, the interview will be anonymised during the transcription process and any identifying information will be removed. All of the information that I collect from people will be stored securely. This information will be destroyed at the end of the study. Your participation in this study would be voluntary. If you do decide to participate you may withdraw your participation at any time. During the interview you have the right to choose not to answer specific questions. I will offer those who take part in this study a summary of the results and the opportunity to discuss any issues that come out of the meetings.

If you would like to talk to me about the study or ask any questions, you can contact me by email at XXX or by phone on XXX.

Thank you very much for taking the time to read this information sheet.

Yours sincerely,

Patsie Staite

Trainee Clinical Psychologist

University of East London

Appendix 4: Consent form for participants

'An exploration of therapists' experiences of therapeutic work with unaccompanied
refugee young people'

Patsie Staite - Trainee Clinical Psychologist

School of Psychology, University of East London

This form is for you to fill in to show that you have given consent to take part in this study. Please read each section and circle 'yes' or 'no' to say whether you agree.

Name of person taking part _____

- Patsie Staite has explained this study and I understand what she is asking me to do. I have read the information sheet and I have been given a copy to keep.

Yes/ No

- I understand that I do not have to take part and that if I do I can stop the research interview whenever I like.

Yes/ No

- I understand that the things I say will be written down and may be directly quoted in the final report. I also understand that this may later be published but my real name and any other details that may identify me or any clients I discuss will not be used.

Yes/ No

- I agree to the discussion being tape-recorded

Yes/ No

- I agree to take part in this study by Patsie Staite

Yes/ No

Signed by the person taking part: _____

Date: _____

I, Patsie Staite, have fully explained to the participant what is involved in this study.

Signed by researcher, Patsie Staite: _____

Date: _____

Appendix 5: Interview Protocol

Questions and information for participant:

- “Before we start, do you have any questions?”
- “Your participation is voluntary, you are welcome to take a break from the interview or to withdraw from the interview at any time”
- “You can chose not to answer specific questions”

- “The interview will be recorded”
- “The content of the interview is confidential”
- “I’ll be asking questions about the process of therapy rather than content of work with particular unaccompanied refugee young people, if you do discuss any specific clients try not to use their names or mention any identifying details – but if you do, the information will be anonymised during transcription”

- “Would you like to be contacted regarding analysis of the interview?”
- “I’ll ask you for feedback about how you found the interview at the end”

Consent form:

- Copy of information sheet
- Sign both copies
- Give one copy to participant and keep other copy

Explanation of the structure of the interview:

- “The interview will begin with questions regarding your details pertinent to the research, before moving onto more open and exploratory questions”

Appendix 6: Transcription procedure

The researcher intended to produce orthographic, word for word level transcripts of the research interviews, as advocated for by Banister et al (1994). The following transcription scheme adapted from the 'Jefferson Lite' approach (Parker, 2005) and was employed when transcribing interviews:

- The transcript was punctuated for readability
- [inaudible] Inaudible section of transcript
- Emphasis Word spoken with more emphasis than others
- [laughter] Laughter during the interview

Layout of the transcripts:

- Each transcript was numbered in accordance with the participant number
- Continuous line numbering was used to number every line of the transcripts
- Transcript documents were customised with a wider margin on the left hand side of each page to allow space for initial coding
- 1.5 spacing was used to ensure space for line-by-line coding

Appendix 7: Semi-structure interview schedules

In accordance with theoretical sampling requirements of the grounded theory approach, the semi-structured interview schedule was adapted over the course of the research following interim analyses conducted for each 'wave' of data collection. Included in this appendix are therefore three versions of the semi-structured interview schedule employed in the research.

The first version was developed prior to the first interview on the basis of sensitising concepts gathered from consultations with professionals working with unaccompanied refugee young people.

The second version of the interview schedule was adapted after constructing an interim analysis of the first four interviews. Additions to the interview schedule are indicated using a different colour font.

The third version of the interview schedule was adapted after constructing an interim analysis of the second three interviews that built on the first interim analysis. Additions to the interview schedule are again indicated using a different colour font.

Appendix 7.1: Semi-structured interview schedule for the first wave of data collection

‘An exploration of therapists’ experiences of therapeutic work with unaccompanied
refugee young people’

Patsie Staite - Trainee Clinical Psychologist

School of Psychology, University of East London

The main interview questions are in bold font. The questions in regular font are intended to be prompts to aid the participant and researcher, if necessary.

1. Demographic details, including:

- Qualification/type of therapist
- What setting(s) do you work in/have you worked in?
- How long have you been qualified as/practiced as a therapist?
- Approximately how many unaccompanied refugee young people have you worked with?

2. How did you come to work with unaccompanied refugee young people?

- What are the kinds of things that you think might have influenced your decision to work with this client group?

3. How do you experience your work with unaccompanied refugee young people?

- How would you describe your work?

- What is the work that you do like for you?

4. How do you experience your role as a therapist in your work with unaccompanied refugee young people?

- What kinds of things did you set out to do when you first started working with unaccompanied refugee young people? Do you think this has changed over the course of your work?
- What do you think are the most important and helpful aspects of the work that you do?
- How do you think your ideas fit with other ideas about therapy and the roles of therapists?
- What do you think are some of the limits to the work that you do and the support you offer in therapy?
- How do you manage these limits in your therapeutic relationships with unaccompanied young people?

5. What therapeutic models or approaches do you employ in your work?

- How do you understand or make sense of your work with unaccompanied refugee young people?
- What kinds of concepts do you draw on to help you understand or make sense of your work?
- How do you attempt to adapt these concepts/models/approaches for use with unaccompanied refugee young people?

6. What are some of the challenges you have experienced in your work with unaccompanied refugee young people?

- What are some of the most difficult things/times that you have experienced in your work? Practically, conceptually, emotionally.
- How do you respond to these challenges?

7. How have your experiences of working with unaccompanied refugee young people changed you professionally and/or personally?

- Are there ways in which working therapeutically with unaccompanied refugee young people has moved you and changed your practice and/or your non-professional life?

8. Debrief and closing the Interview

- Thank you very much for taking part in the interview
- Do you feel that the interview has covered all of the important aspects of your experiences of your work, if not what else should be covered?
- Is there anything further that you would like to say?
- How has the interview been for you? Do you have any feedback for me?
- Do you have any questions for me?
- Thank you again

Appendix 7.2: Semi-structured interview schedule for the second wave of data collection

‘An exploration of therapists’ experiences of therapeutic work with unaccompanied
refugee young people’

Patsie Staite - Trainee Clinical Psychologist

School of Psychology, University of East London

The main interview questions are in bold font. The questions in regular font are intended to be prompts to aid the participant and researcher, if necessary.

1. Demographic details, including:

- Qualification/type of therapist
- What setting(s) do you work in/have you worked in?
- How long have you been qualified as/practiced as a therapist?
- Approximately how many unaccompanied refugee young people have you worked with?

2. History: how did you come to work with unaccompanied refugee young people?

- What are the kinds of things that you think might have influenced your decision to work with this client group?

3. How do you experience your work with unaccompanied refugee young people?

- How would you describe your work?

- What is the work that you do like for you?

4. How do you experience your role as a therapist in your work with unaccompanied refugee young people?

- What kinds of things did you set out to do when you first started working with unaccompanied refugee young people? Do you think this has changed over the course of your work?
- What do you think are the most important and helpful aspects of the work that you do?

5. How do you experience developing therapeutic relationships with unaccompanied refugee young people?

- How do you make sense of 'therapy' with unaccompanied refugee young people of the work that you do?
- What do you think the unaccompanied refugee young people understand to be/experience as the most helpful aspects of the work?

9. How would you describe your approach to working therapeutically with unaccompanied refugee young people?

- What kinds of concepts, models, approaches or ideas have you found helpful to understand or make sense of your work?
- How do you attempt to adapt these concepts/models/approaches for use with unaccompanied refugee young people?
- How do you think your ways of working fit with other approaches to therapy or the roles of therapists?

- How do you make sense of any differences in how you have worked with different young people?

6. What are some of the challenges you have experienced in your work with unaccompanied refugee young people?

- What are some of the most difficult things/times that you have experienced in your work? Practically, conceptually, emotionally, [socially](#), [at a service level](#)?
- How do you respond to these challenges?
- What do you think are some of limits to [what you can do in your work and the support](#) that you can offer within therapy?
- How do you manage these limits ([what you can and can't do](#)) within your therapeutic relationships with the young people that you work with?

7. How have your experiences of working with unaccompanied refugee young people affected you professionally and/or personally?

- What kinds of affects have you noticed working with unaccompanied refugee young people has had on you? Personally, professionally?

8. How have your experiences of working with unaccompanied refugee young people changed you professionally and/or personally?

- What are the ways in which working therapeutically with unaccompanied refugee young people has moved you and changed your practice and/or your non-professional life?

10. Debrief and closing the Interview

- Do you feel that the interview has covered all of the important aspects of your experiences of your work, if not what else should be covered?
- Is there anything further that you would like to say?
- Thank you very much for taking part in the interview
- How has the interview been for you? Do you have any feedback for me?
- Do you have any questions for me?
- Thank you again

Appendix 7.3: Semi-structured interview schedule for the third wave of data collection

‘An exploration of therapists’ experiences of therapeutic work with unaccompanied
refugee young people’

Patsie Staite - Trainee Clinical Psychologist

School of Psychology, University of East London

The main interview questions are in bold font. The questions in regular font are intended to be prompts to aid the participant and researcher, if necessary.

1. Demographic details, including:

- Qualification/type of therapist
- What setting(s) do you work in/have you worked in?
- How long have you been qualified as/practiced as a therapist?
- Approximately how many unaccompanied refugee young people have you worked with?

2. History: how did you come to work with unaccompanied refugee young people?

- What are the kinds of things that you think might have influenced your decision to work with this client group?

3. How do you experience your work with unaccompanied refugee young people?

- How would you describe your work?
- What is the work that you do like for you?

4. How do you experience your role as a therapist in your work with unaccompanied refugee young people?

- What kinds of things did you set out to do when you first started working with unaccompanied refugee young people? Do you think this has changed over the course of your work?
- What do you think are the most important and helpful aspects of the work that you do?

5. How do you experience building therapeutic relationships with unaccompanied refugee young people?

- How do you make sense of/develop a shared understanding with unaccompanied refugee young people of the work that you do?
- What do you think the unaccompanied refugee young people understand to be/experience as the most helpful aspects of the work?

6. How would you describe your approach to working therapeutically with unaccompanied refugee young people?

- What kinds of concepts, models, approaches or ideas have you found helpful to understand or make sense of your work?
- What is your experience of using psychological concepts in working with UASC?
- How do you attempt to adapt these concepts/models/approaches for use with unaccompanied refugee young people?

- How do you think your ways of working fit with other approaches to therapy or the roles of therapists?
- How do you make sense of any differences in how you have worked with different young people?

7. What are some of the challenges you have experienced in your work with unaccompanied refugee young people?

- What are some of the most difficult things/times that you have experienced in your work? Practically, conceptually, emotionally, [socially](#), [at a service level](#)?
- How do you respond to these challenges?
- What do you think are some of limits to [what you can do in your work and the support](#) that you can offer within therapy?
- How do you manage these limits ([what you can and can't do](#)) within your therapeutic relationships with the young people that you work with?

8. How have your experiences of working with unaccompanied refugee young people affected you professionally and/or personally?

- What kinds of effects have you noticed working with unaccompanied refugee young people has had on you? Personally, professionally?

9. How have your experiences of working with unaccompanied refugee young people changed you professionally and/or personally?

- What are the ways in which working therapeutically with unaccompanied refugee young people has moved you and changed your practice and/or your non-professional life?

10. Debrief and closing the Interview

- Do you feel that the interview has covered all of the important aspects of your experiences of your work, if not what else should be covered?
- Is there anything further that you would like to say?
- Thank you very much for taking part in the interview
- How has the interview been for you? Do you have any feedback for me?
- Do you have any questions for me?
- Thank you again

Appendix 8: Example of initial coding

Below is an excerpt from the research interview with participant 9 to show initial line-by-line coding of the transcript. In the transcript, 'T' refers to 'therapist' or participant.

	<p>Patsie: What has your experience been of, or what have you found to be, some of the challenges of working with unaccompanied children and how have you found ways of responding to those challenges?</p>
<p>Wanting to rescue Powerless to influence decisions Not talking about 'trauma' Seeing effects of trauma on children 'Working with unfair system' Helping children through 'unfair' experiences Feeling upset, uncomfortable – sense of injustice</p>	<p>T: Okay um. Firstly the challenges, well totally number one is managing wanting to rescue these young people, because of course you can't. You can write a court report but you can't force the Home Office to make a certain decision. So I think that's a challenge. Another challenge is when you're working with somebody who is really struggling with traumatic experiences but they also don't want to talk about them. A lot of our unaccompanied young people have poor sleep, get angry very easily, have terrible concentration, all those kinds of effects that you'd expect, have flashbacks, but aren't ready to talk about them. Working with a very unfair system, coming up against, having to help them through bad experiences, where they've had a foster placement terminated with no notice or a solicitor who's said "right your money is up, I can't offer you any more" or an uncomfortable interrogation where they've had to talk about their asylum status. Those kinds of things can be very hard to manage in therapy where young people are talking about the very unfair system in Britain and it feels very upsetting, to think that they've come to seek asylum here and a lot of their problems are very traumatic and ongoing. It feels horrible and uncomfortable that we live in a country that does that to young people and doesn't look after people properly when they come. So I suppose I find that very difficult and challenging.</p>
	<p>Patsie: How have those challenges impacted on you both personally and/or professionally?</p>
<p>'Getting personally involved' Becoming</p>	<p>T: Hmm, I suppose at times getting very personally involved. I don't know if I've become a bit hardened but I'm aware of needing to go home to my own family and leaving it behind, I think I've become quite good at doing that. I think earlier in my career I would have had more sleepless nights, but now,</p>

<p>hardened</p> <p>Being aware of</p> <p>own needs</p> <p>Not taking</p> <p>work home</p> <p>'Going extra</p> <p>mile'</p> <p>Wondering</p> <p>about</p> <p>becoming</p> <p>foster-carer</p>	<p>unless someone's kind of, unless I'm concerned about risk and somebody harming themselves, but even then I would make sure I do all I can before leaving work, even if that meant staying late. So I don't think I take things home in a way that I resent or in a way that could impact on my home life. I think there are times here when I'm aware I'm staying late to go the extra mile, so it has an impact in that way. And I probably do put in the extra work for the unaccompanied minors I'm working with. It's made me wonder about becoming a foster carer and lots of fantasies about opening my family up, but then I realise that practically that's not what I want or would be able to take on.</p>
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Appendix 9: Example of focused codes subsuming initial codes

Below are examples of initial codes subsumed under focused codes relating to participants' accounts of using the concept of 'trauma' and the diagnosis of PTSD in therapeutic work with unaccompanied children. The focused codes were developed during the construction of the third interim analysis. Focused codes are written in *italics*. Numbers in brackets represent the participant number for each initial code.

Memo: focused coding, 16.01.12

Working with 'trauma'

- Doing trauma-focused work with UASC (8)
- UASC being referred for past traumas, depression and anxiety issues (8)
- UASC not wanting/not being ready to talk about traumatic experiences but struggling with effects, children wanting effects of trauma to go away, children wanting to get on with their lives (9)
- Therapists seeing effects of trauma on UASC (9)
- Experiences in country of origin still being active in children, children reliving traumatic experiences in country of origin (4)

Focusing on present, rather than past (2)

- Continuing trauma (5)
- Holding not resolving trauma (5)
- Focusing on here & now (5)
- Children not being able to resolve issues because do not have permanent status in the UK (3)
- Children's impermanent status in the UK affecting their mental health and therapeutic work that can be done (3)
- Not jumping into trauma aspect of work (2)
- Not focusing on trauma when child is more concerned with their living conditions or asylum application (2)

- Children trying to cope with here and now in the UK being catapulted into a foreign land, being catapulted into poverty in their life in the UK, coping with losing their culture and acculturation, housing problems, learning English, education, being on their own, isolation, learning skills for independent living (2)
- Not trying to resolve trauma if UASC could be deported imminently (3)
- Trauma happening not happened (3)
- Not focusing on the resolution and change emphasised in Western models (3)
- PTSD literature focusing on resolving trauma, Western therapy models focusing on dealing with loss, Western therapy models aiming for resolution not just management (3)
- Children not being in a position to resolve loss and trauma, children knowing they could be returned when they are 18 or before, children not being in stable enough situation to explore trauma in depth, Focusing on managing what's happening in here and now, Waiting until children can look at past experiences in more depth (3)
- Working in the here and now, Not dwelling on the past, Dealing with the present, Enabling children to move forward (7)
- Children experiencing continuing trauma, Trauma being in present not past for children, Trauma still happening, not happened for children, Therapists bearing in mind that trauma is happening now, not only in the past (4)

Doing trauma work

- Accessing trauma, verbalising experiences, writing children's stories (5)
- Doing trauma work with children, Therapists supporting children to deal with trauma (7)
- Enabling children to making sense of what happened to them (7)
- Enabling children's recovery from trauma and PTSD symptoms (7)
- Enabling children to function (7)

- Enabling children's to understand and come to terms with their experiences (7)
- Children putting their experiences behind them (7)

Preoccupation with/destabilising effect of asylum application preventing therapy work

- Question of leave to remain hanging over children's heads (8)
- Asylum application taking up children's lives and relationships with professionals (8)
- Children's lives being dominated by asylum application and not knowing (8)
- Thinking about mental health issues being difficult for children (8)
- Children being preoccupied by asylum application (8)
- Asylum application hindering therapeutic work (8)
- Children not knowing where they'll be living therefore not being able to think of other things, e.g. mental health and therapy (8)
- Children not being ready to talk if don't know where they'll be living (8)
- Stopping therapeutic work or waiting to start therapy until child is ready (8)
- Questioning 'right time' for therapy (8)
- Basics needing to be established for children before therapy (8)

Employing concept of PTSD

Using helpful elements of PTSD concept

- Using PTSD in court reports (1)
- Naming PTSD to help children access services/resources (1)
- Focusing on vulnerabilities being helpful sometimes (1)
- Using PTSD models to help children manage/deal with/move on from symptoms and trauma (1)
- Children experiencing distressing symptoms (7)

- Explaining PTSD (5), Explaining PTSD to children, Linking children's past experiences to PTSD symptoms, Explaining somatic symptoms, Understanding PTSD symptoms as expressions of experiences, Developing children's understanding of PTSD symptoms (7)
- Normalising children's experiences, using PTS concept to normalise children's experiences, reassure they are not 'going mad', being able to explain to children why their symptoms are happening, children feeling relieved when therapists explain normal PTS symptoms, children feeling that someone else understands what's happening for them (3)
- Making connection between mind and body, Drawing diagrams to make links between mind and body (6)
- Explaining reactions to events (6)
- Normalising PTSD symptoms/reliving traumatic experiences, Reassuring children not going crazy (6)
- Explaining panic attacks, Offering alternative explanations to 'heart attack' (6)

Being careful when using PTSD diagnosis

- Children not being straightforward 'PTSD' cases (8)
- Children having PTSD features but managing to function (8)
- Children experiencing issues other than PTSD and trauma (8)
- PTSD not fitting exactly for children (8)
- Children being embedded in variety of different contexts (8)
- PTSD concept not fitting with complexity and context of children's lives (8)
- Children having a range of life experiences, not only specific problems (8)
- Not placing Western criteria on what children bring (3)
- Not wanting to pathologise children's experiences, using 'PTS' and not 'D' (3)
- Contextualising children's experiences (5)
- PTSD focusing on vulnerabilities being unhelpful for children at other times; PTSD models missing children's resilience (1)
- Being aware that PTSD and refugees are so strongly connected they can become synonymous (1)

- Being careful PTSD does not become children's identity (1)
- Not labelling children as 'traumatised' and 'damaged', labels becoming UASC's identity, labels being hard for children to move on from (2)
- Looking beyond PTSD label, thinking about children holistically, thinking about children's experiences of family, childhood (6)
- Getting past 'refugee' label, seeing children as individuals like anyone else, children label hindering holistic thinking, holding children's histories in mind, exploring beyond UASC label (6)
- Being pushed to go beyond PTSD label, Going beyond convenient labels (6)
- Viewing children's experiences in different ways (6)
- Conceptualising UASC's experiences as psychosomatic PTSD symptoms (6)
- Thinking about children's history (6)
- Thinking about children's relationships with their parents, attachments (6)
- Hypothesising about what shaped children (6)

Appendix 10: Development of the grounded theory

Below are extracts from each of the three interim analyses to demonstrate the development of the grounded theory. Excerpts have been selected to illustrate the construction of the category 'meeting children where they are emotionally' over the course of the research. After the first wave of interviews, the provisional category 'focusing on the therapeutic relationship' was generated, which included the sub-categories 'forming a relationship', 'providing a sense of safety', 'building trust' and 'letting children know they matter'.

In the second interim analysis, the category was expanded to conceptualise participants' accounts of 'being with' children in therapeutic work. This included the sub-categories 'being there', 'being human', 'spending time together', 'letting children know they matter' and 'using fundamental therapeutic skills'. In the third interim analysis, the category 'being with' children was subsumed within the category 'meeting children emotionally'. This category included 'following children's lead', 'setting therapy apart from the asylum system', 'going against the culture of disbelief', 'being a break from isolation' and 'building trust'. The interim analyses provided the bulk of the content presented in the analysis chapter the research.

10.1 First interim analysis

Focusing on the therapeutic relationship

As part of 'doing what works', participants emphasised the importance of focusing on forming a relationship with children. Participants talked about the therapeutic relationship providing a secure base, stability and creating a sense of safety for children. This was described as being crucial in therapeutic work with children and may be connected to the lack of security, stability and safety many children experience both prior to arriving in the UK and in the UK. Participants spoke of the importance of building trust in relationships with children, reservations children may have about trusting therapists, the importance of children not trusting people too quickly, and instead being able to judge who might be worthy of their trust.

Participants spoke of the importance of letting children know they matter and holding onto hope through the difficult experiences that children endure.

Forming a relationship

- “it’s about finding what fits and you can’t do that until you create a relationship and trust [Patsie: mm] and that young person will let you in” (2, 139-141)
- “we focused on just forming a connection [Patsie: mm] and left everything else...just connecting and just letting that young person know that they were important and that was, if we achieved that, it worked” (3, 226-230)

Providing a sense of security

- “I think um something...I think is pivotal, which is about that creation of a secure base...I think no matter what therapy or what you’re coming from theoretically that sort of, the creation of the sense of safety and of the sense that you can say and experience or talk about anything you want um and that somebody is there for you. I think that’s absolutely crucial...So I think the creation of a strong therapeutic alliance in terms of safety is absolutely crucial and more crucial I think perhaps for unaccompanied young people” (1, 731-742)
- “there’s something about the attachment with unaccompanied minors it’s much stronger than the attachment I feel with any other client group” (4, 625-627)
- “I think we’re just like a constant, we become their constant figure...it’s providing stability [Patsie: mm], providing something that they don’t have, a constant” (4, 470-479)
- “I sort of had to put things into perspective about what was important in our work so what could I do for him?...I could let him know that regardless of what was going on in his life this was a safe space...and I would always be pleased to see him. And actually, when you’ve got nothing, that becomes quite important” (3, 347-352)

Building trust

- “once you do a little bit of trust building and work on those practical issues and you’re more flexible than just sitting in your therapeutic room [Patsie: mm] they trust you, or you do the phone call in front of them with them to sort out their gas or whatever, they see that you actually care on the levels that they want to bring and once that trust develops then you go to another phase where they start to tell you about what they have, what their dreams are about or what their nightmares are about, what is really personal [Patsie: mm], so it takes time” (2, 125-132)
- “I find with that group it’s much harder for them to trust a counsellor, they don’t know, it’s like everybody’s telling them that everything’s confidential but they don’t really know if it is [Patsie: mm]. Because then they’re in some panel meeting where everything is being discussed...schools always have concerns about them...and then we go into the school and it’s “ok the teachers have brought these people in, who are they, why should I trust them and what are they going to do?”” (4, 253-262)
- “bearing in mind the majority of the people we work with will be removed from the UK ultimately, we need to be aware that actually we don’t want them to develop too quickly a trusting relationship with us [Patsie: okay] and it might be that we need to reinforce that actually they need to check out who we are [Patsie: mm]. Sometimes the kids come in and engage too quickly and I will say to them “do you know where I’m from and do you know why I’m here?” because often they’re not clear, and we’ll just have a chat about “you need to be really careful about who you talk to about your life and how can I help you to judge that, before we talk about me or you let’s just think about how do you know?”.” (3, 458-467)

Letting children know they matter

- “just letting that young person know that they were important and that was, if we achieved that, it worked” (3, 228-230)

- “if we can just communicate those things and show a young person who has gone through so much that they are valued [Patsie: mm], then that to me feels like the start of healing” (3, 432-434)
- “Risk is the hardest...you are working so hard to convey a bridge that there are people who are holding on the hope and believe that your life is a beautiful life that is worth holding onto.” (2, 318-324)

10.2 Second interim analysis

‘Being’ with children

In their interviews, participants described particular ways of being that were constructed as facilitating building therapeutic relationships with children. From participants’ descriptions, five sub-categories were constructed to conceptualise different aspects of ‘being’ with children: ‘being there’, ‘being human’, ‘spending time together’, ‘letting children know they matter’ and ‘using fundamental therapeutic skills’. These sub-categories seemed to represent participants putting aside ‘doing’ therapy to simply focus on being with children and building a therapeutic relationship.

Being there

Participants consistently spoke of ‘being there’ for children as crucial in building the therapeutic relationship and in therapeutic work with children. ‘Being there’ involves being a consistent and reliable figure in children’s lives and children feeling that the therapist is holding them in mind, looking out for them and on their side. In ‘being there’ for children, participants aim to give children a sense of safety and stability in contrast to the lack of safety and stability they may have experienced in their country of origin and the UK. Through consistently ‘being there’, participants described a process in which children begin to create a secure base within the therapeutic relationship from which they are able to navigate systems in the UK and build a life for themselves.

Being human

Participants referred to an idea of 'being human' with children. 'Being human' means being warm and genuine and they care about the children. This seems to play a part in therapists creating a 'connection' with children. In 'being human' with children, participants spoke of their awareness of children's loneliness and isolation meaning that children might be in need of 'human contact'. 'Being human' with children means that therapists might at times expect to do nothing more than be a point of contact for children as a break in this loneliness and isolation.

Spending time together

'Spending time together' was described as an important element of beginning therapeutic work with children. This was based on participants' observations of how powerful it can be 'just to be' with children. 'Spending time together' means not imposing anything or putting pressure on children and the therapist putting their agendas aside to focus on building a rapport with children. In doing so, participants described taking time and working at the children's pace; giving them control by following their lead and working with what they bring to therapy sessions. Participants spoke of the importance of showing they care about what children bring in providing an antidote to children's experiences of the culture of disbelief in the UK by taking what they bring seriously.

Letting children know they matter

'Letting children know that they matter' was a significant aspect of therapeutic work in the context of their experiences of discrimination in the UK and feelings of hopelessness with regard to the possibility of being deported from the UK. Participants 'letting children know they matter' involves showing children that they are accepted, respected and valued by the therapist. Believing in children and their stories was one way of letting children know they matter. Communicating that they are valued also meant believing that children's lives are worth living and holding

onto hope for their future. Participants described doing this by looking out for children's achievements and strengths in their daily lives, giving children positive feedback about this and building on these achievements to give them a sense of hope and optimism.

Using fundamental therapeutic skills

In 'being with' children, participants described 'going back to basics' in their work and employing their most fundamental therapeutic skills. 'Using fundamental therapeutic skills' meant giving children space to share their pain and bearing witness to what they shared; listening to children, empathising with and acknowledging their pain. Overall, participants described a process of holding and containing children emotionally whilst processing their emotions and developing an understanding of what might be happening for them to bring into the therapeutic work.

10.3 Third interim analysis

Meeting children 'where they are' emotionally

Meeting children where they are emotionally involves therapists being aware of the experiences children are likely to face upon arriving in the UK and responding to what they perceive as children's emotional needs. During the interviews, participants described their understandings of children's initial experiences in the UK and adapting their approach to beginning therapeutic work accordingly. Five elements of children's experiences constructed as pertinent in therapists shaping their approach to beginning therapeutic work and meeting their needs are children's experiences of interrogation, their treatment by the UK asylum system, disbelief, their isolation and wariness of professionals in the UK.

Following children's lead

Upon arriving in the UK, participants described children facing immediate questioning through multiple interviews in which they may experience feeling dismissed and rejected. As a result, therapists constructed children as arriving to therapy 'exhausted' and fearing further interrogation and disbelief. Rather than beginning therapeutic work by conducting a formal 'assessment', meeting children where they are emotionally means responding to fears of further interrogation by putting 'conventional' therapy assessments and information gathering agendas aside. Instead, therapists adapt their approach to beginning therapeutic work in order to respond to children's needs by giving children control, letting children know they do not have to share information if they do not wish to do so and following their lead through focusing on what they bring. For therapists, this involves being patient and giving children time and space to talk without pressure.

"they have a series of interviews after interviews and interrogations after interrogation so they come quite exhausted. And interrogation will be the last thing they want from a professional like myself...So that needs to be put aside for the time being. So when I see them I don't take notes. It's just a brief conversation, just being there with them" (7, 75-80)

"whereas we used to have an assessment session, that might now take three weeks because we've found that a lot of the boys have said to us...they don't want to talk about their families or anything like that, with a stranger...they're just saying like "why would they say something about their families? Why would we want to know?" It's fair enough, isn't it really? So we've had to change the way that we work" (3, 450-457)

"we do explain that...if there are things they don't particularly feel they want to talk about or they don't want to disclose...that's totally ok" (7, 138-142)

"So children slowly open up, it might not happen in the first session um there's a lot more having to be patient around the opening up and not being pushy" (4, 385-387)

“it’s what they bring though, it’s not what you impose, they bring their stories and their difficulties and what they want to do” (2, 117-118)

Setting therapy apart from the asylum system

Children’s initial experiences of professionals and services are likely to be with social structures within the UK asylum system, such as the Home Office and National Asylum Service (NAS). Participants described children bringing their experiences of the UK asylum system to therapy and fearing therapists may be ‘another official’ checking the ‘truth’ of their story. Meeting children where they are therefore means therapists setting themselves apart from the UK asylum system to respond to and alleviate children’s fears of further interrogation and disbelief. Participants set themselves apart by letting children know that therapy services are separate to the UK asylum system and by differentiating the role of therapists as supporting and advocating for children rather than questioning or interrogating.

“how am I different...because...young people come to this country, they have all kinds of interviews with people in all kinds of ways, so how do I distinguish myself...“I’m not the home office”” (1, 408-411)

“we let them know from the beginning. I think that has to be explicit, that we are not the home office. Sometimes a lot of it is dispelling the fear...of “oh another official...who’s going to check out my story”... the culture of disbelief is so strong, one of the things I think is important...is to be explicit about the role of the team, that actually we are here to offer support” (2, 173-183)

“we do explain that we are not the home office. We make it very clear we are not any other agencies. That we work with them for their own benefit, we are there for them, we are their advocates” (7, 138-140)

Going against the culture of disbelief

In response to the culture of disbelief asylum seeking people experience in the UK, participants constructed children as needing to have a sense of being believed by therapists. Meeting children where they are therefore means therapists putting Western therapy ideas of 'neutrality' aside and being non-neutral in their therapeutic work in order to go against the culture of disbelief in the UK. Going against the culture of disbelief involves therapists taking a non-judgmental stance towards children and descriptions of their experiences, explicitly going against discriminatory social policies and practices by stating the view that 'refugee people are welcome in the UK', using psychological research to understand children's presentations rather than disbelieving them, advocating on behalf of children and working to empower children by enabling them to voice their needs rather than being 'compliant' and 'grateful'. Participants spoke of the importance of showing they care about what children bring in providing an antidote to children's experiences of the culture of disbelief in the UK by taking what they bring seriously.

"Your role is not to make judgements about what people do to survive...I don't care if what they're telling is true or not, that's not your job. Your job is to try to help...You've got to be realistic that people are going to do all sorts of things to survive and get on in life, I don't think it's a crime" (8, 404-410)

"if you don't believe in some of the issues that asylum seekers and refugees have and you're not of the political mindset that they are welcome, that's going to come a cropper...If you are actually in a service where "if you are a refugee or an asylum seeker then you are welcome" you know, you see that person in a different way...And our service has got that upfront" (2, 160-169)

"There's the thinking of "what are you here for?"...Then we have to step in to explain that they didn't chose to come, they come because they want to live. Because of fear of dying and every human being has a right to live, it's a human right to live and not to be murdered or to be tortured, not to be persecuted. So that's constantly making people aware of that" (7, 338-344)

"There is an expectation of unaccompanied minors to be compliant and an expectation of gratitude from the system around them, because they come to

this country and it costs a huge amount of money to accommodate them so that's also unspoken in the background" (8, 399-402)

"I sometimes say to children "I feel furious that was allowed to happen to you", because it enables them to question maltreatment" (5, 37-39)

"they get a message of "you're so lucky to be here, you should be grateful and not ask for anything else"...Unaccompanied minors don't have a voice, it's important to get them heard, we need to use our position to empower them" (5, 169-177)

"We take their problems seriously, you know, we don't dismiss them...Their problems are accepted and we work with them and I think they find that really, really helpful" (3, 521-528)

Being a break from isolation

During the interviews, participants explained children come to the UK on their own, may not know anyone in the UK and often feel lonely, isolated and in need of human contact. In response to children's loneliness and isolation, therapists described therapeutic work as initially being a break from isolation and providing human contact. Meeting children where they are at the beginning of therapeutic work means therapists not expecting to be more than a break in children's isolation. Being a break from isolation was constructed as involving spending time together and be someone they can turn to by providing the 'normal' human contact they are missing through doing things like having cups of tea and reading newspapers together. This was based on participants' observations of how powerful it can be 'just to be' with children.

Participants spoke of their awareness of children's loneliness and isolation meaning that children might be in need of 'human contact'. 'Being human' with children means that therapists might at times expect to do nothing more than be a point of contact for children as a break in this loneliness and isolation.

“They want that human contact so they will come to the sessions very regularly...going to see someone who is there for them. Someone who they can talk to, who they can trust, another human being. They are often very isolated... at the end of the day they go back home alone to their little flat or to their little clusters, confined to their own rooms” (8, 102-116)

“we’re a break in that isolation...they’re not quite so lonely anymore” (4, 622-625)

“They encounter so many systems and have to attend so many meetings and I think sometimes they really appreciate those little moments in between all of that where it can all be a bit more normal. Where you can pick up the Metro and like look at the front page and have a chat about that, those normal day to day chats that you have with people...I do think it’s quite nice for them sometimes to be able to just have a cup of tea and look at the paper with someone and to have someone say in quite a human way “are you okay?” (6, 386-398)

“Counselling gives UASC a human connection, which they’ve lost with everyone else that has ever been in their life in their country of origin” (5, 52-53)

Building trust

From their experiences of arriving in the UK, participants describe children as learning to be wary of and not trust people – particularly ‘helping’ professionals who have often not been experienced as helpful. Meeting children where they are in the beginning of therapy means therapists understanding reservations children may have about trusting them and the reasons why children may be wary of them. Participants described themselves as being ‘another professional’ that children meet in a long line of services and agencies. Over the course of their interactions with social structures in the UK, participants described children as becoming so used to sharing their stories with professionals that making a connection with therapists becomes more difficult, placing an initial barrier in terms of beginning to develop a

therapeutic relationship. One participant spoke of the importance of children not trusting people too quickly and instead being able to judge who might be worthy of their trust, encouraging children to be wary of people in order to ensure they keep themselves safe.

"I think that these are major issues around...not trusting people for good reasons" (8, 84-86)

"They can come across as not very trusting and not really wanting to give too much of what they've been through, where they are coming from. Because they worry of who is listening and where it's going to get to" (7, 71-73)

"some of the young people when I first start working with them they're a bit wary, they don't know you and it's not really clear what my role is" (6, 333-335)

"they've travelled for months and then they get here and it's a bit of a rejection...all these interviews, so I think trust is around "who can I trust? Who's going to help me? My social worker told me to go there [to therapy], but do I trust this person [therapist]?" (4, 245-249)

"bearing in mind the majority of the people we work with will be removed from the UK...we don't want them to develop too quickly a trusting relationship with us...it might be that we need to reinforce that actually they need to check out who we are. Sometimes the kids come in and engage too quickly and I will say to them..."you need to be really careful about who you talk to about your life and how can I help you to judge that?" (3, 458-466)

Meeting children where they are involves putting therapy models and techniques aside to enable therapists to focus on getting to know each other, building trust and a therapeutic relationship.

"I think the most important part of the therapy is the relationship that you build with them and the trust that they have of going to see someone who is there for them" (7, 109-112)

“we focused on just forming a connection and left everything else...just connecting and...if we achieved that, it worked. Because they were then likely to come back” (3, 226-231)

“it’s about finding what fits and you can’t do that until you create a relationship and trust [Patsie: mm] and that young person will let you in” (2, 139-141)

“I don’t think therapy is about “you do this, that and that” or...do specific techniques. I think fundamentally it’s about making a relationship with another person...Although not everyone would agree with that and you’ve got to use the evidence base...But I think you can incorporate all that afterwards, once you have the basics. If you’re not going to get on with someone, you’re not going to be able to work with them – so it doesn’t matter what you do or if you’re amazing at relaxation or negative automatic thoughts, if they’re not going to like you they’re not going to come back. You have to relate to each other to eventually get anywhere” (8, 221-234)

Appendix 11: Example of 'free-writing' memo

Below is an example of a memo developed through 'free-writing' during the second interim analysis to conceptualise and explore the properties of the provisional category 'being with' children, which was later subsumed under the category 'meeting children where they are emotionally'.

Memo: Building therapeutic relationship by 'being with' children, 03.01.12

Being there for children and holding them in mind – 'being on their side'/looking out for them, being a consistent and reliable figure in children's lives, giving children a sense of safety in therapy/with therapist, providing stability, includes using same interpreter for continuity; therapists aim to create a secure base for children within the therapeutic relationship from which children can navigate other systems and go on to settle in the UK

Being a significant person in children's lives – being a break from their isolation and loneliness, being the 'only one' who children can talk to or turn to, who remembers their birthday; taking a significant place in children's lives (quote from interview 1); 'being the only one' vs. 'being someone'

Holding onto hope for children and giving children a sense of hope, letting children know that they matter, they are accepted, respected, important and are valued, unconditional positive regard, believing that their life is worth living and that there is a purpose to their living, believing in children and believing their stories; showing therapist has an understanding of and respect for children's cultures and an awareness of children's cultural/religious needs, being sensitive towards children's culture; giving children a sense of acceptance and belonging; looking out for and noticing children's achievements and strengths, giving positive feedback, building on achievements

Being 'human' with children means being warm children being genuine, creating a connection, showing therapist cares and checking UASC is okay/being sensitive to where they are; a response to children's situation – lonely and isolated – being

aware that children might be wanting human contact, therapy providing a break from isolation and loneliness; is being 'human' different to being a 'therapist'? Sitting in cafes with children, having cups of tea together and informal chats – how do 'informal chats' differ/compare to formal ones? Going to where children are rather than meeting in the clinic, ensuring therapeutic space is comfortable, not threatening/frightening

Spending time together, being aware of how powerful it can be just to be with someone, following children's lead and not imposing or asking anything on/of children, not putting pressure on children – working with/focusing on/responding to and showing you care about what children brings and take what they bring/their problems seriously rather than therapist having own agenda (leaving everything else and just focusing on therapeutic relationship) or dismissing what children brings, putting information gathering aside, not taking notes; taking time and working at children's pace – not delving too deep too quickly, beginning by getting to know each other and building rapport with children, giving children control, children might tell therapist a little bit about themselves and be curious to know about the therapist, children might seek/invite reciprocal relationship

Giving children space to share their pain, listening, empathising, acknowledging, bearing witness and reassuring, holding and containing children emotionally, processing and developing an understanding of children's emotions, holding children in mind and letting children know that therapist is doing that

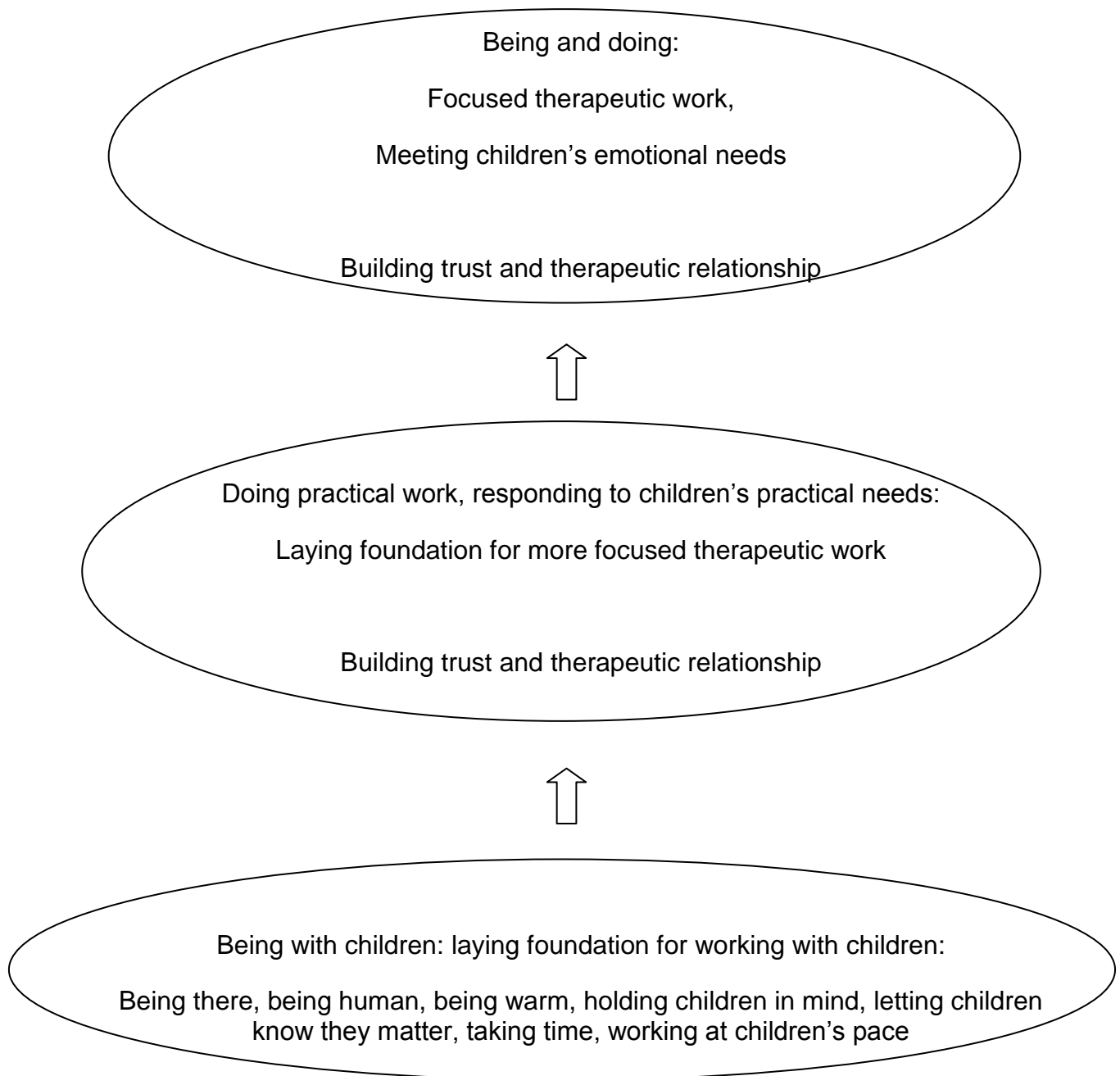
All of this facilitates building trust and forming a therapeutic relationship with children's, which therapists describe as crucial within the therapy

Connected to the lack of security, stability and safety many children experience both prior to arriving in the UK and in the UK.

Appendix 12: Example of 'clustering' memo

Below is an example of a clustering memo constructed during the second interim analysis to explore relationships between 'being' with children, later subsumed under 'meeting children emotionally', and 'doing' practical work with children, which was subsumed under 'meeting children practically'.

Memo: Diagram for 'being' and 'doing' in therapeutic work, 24.12.11



Appendix 13: Extracts from reflexive diary

A reflexive diary was kept throughout the research to provide a space for the researcher to record thoughts regarding the research process and reflect on taken-for-granted assumptions and values. Extracts have been included from the diary to provide examples of the researcher's reflexivity and responses to reflections during the study. Excerpts were selected to illustrate challenges experienced and reflected on during data collection and analysis and responses to these reflections.

Reflections following interview with participant 1, June 2011

During and after the interview, I felt humbled, inspired and moved by the stories and reflections shared by the participant. This feeling struck me in every interview I conducted. Alongside a sense of frustration and sadness in the participants' stories, there was much laughter. I wondered whether this was a way of indicating a shared understanding or embarrassment, or perhaps it was a way of coping with the distress of the work the participant was discussing. In reflecting on these kinds of questions, I was aware of their importance in data analysis and therefore ensured I included these in analytic memos. In the grounded theory approach I noticed much overlap between analytic memo-writing and recording the reflexive diary. I often, therefore, transferred my thoughts and reflections from the diary to memos.

I reflected on the challenge of my dual role in training as a therapist and also a researcher. As this was the first research interview I had ever conducted, I was struck by the differences between therapy and interviewing for research purposes. I found myself wanting to respond to the participant in ways I might do in therapy. Responding therapeutically was ethically appropriate in terms of the emotions that arose during the interview. However, I was aware of balancing this with information gathering for the purpose of the research. The semi-structured interview schedule was helpful to refer back to and direct information gathering.

I had a moment of anxiety during the interview after I had asked the first question on the interview schedule about 'how did you come to work with unaccompanied refugee young people?'. The participant's response seemed to cover at once all of

the areas I was planning to ask questions about over the course of the interview. When she finished speaking, it was clearly my turn to respond and I was unsure of what direction to take. On reflection, I decided that in future interviews it would be helpful to memorise the main areas of questioning so that I could respond more quickly – rather than going through the pages of my interview schedule, trying to figure out what to ask next. I highlighted the main areas of questioning in the interviews as: the *history* of therapeutic work with unaccompanied children, *general experiences* in the work, experiences of the *role*, therapeutic *approach* and challenges, as well as *impact* of the work on participants. This helped me to remain grounded in the schedule during the interviews.

The participant's answers my questions also included numerous issues I was curious to follow-up on. In the interview I realised I had been so engaged in the participant's response to my first question, that I had not made notes to direct further questioning in response to the different issues her answer had covered. I rectified this as the interview continued by making sure I noted down words and phrases to refer back to and to direct follow-up questions.

During the interview I felt that the participant and I developed a rapport, which created a sense of safety for the participant to share an open account of her therapeutic work. In the interview and when transcribing the data, I was struck by the richness of the data and excited by the numerous analytic possibilities in the data. I wondered if perhaps it had been my engagement with the participant's narrative during the interview and my therapeutic responses to the emotions that arose that had enhanced the richness of the data (I am aware that using the word 'data' might demean the participant's emotions, struggles and real life experiences).

Whilst transcribing I also noticed a number of issues the participant had touched on during the interview that I wished I had followed-up on. I was mindful that it would not be possible to follow-up on every issue raised during interviews. On reflection, however, I wondered if I could have balanced my engagement with maintaining some distance to enable me to notice more of these issues during the interview, instead of afterwards. After interviews, I also decided to ensure that I recorded memos of issues I would have liked to explore further in order to shape theoretical

sampling when adapting the semi-structured interview schedule for the next wave of data collection.

Reflections following interview with participant 2, July 2011

The first and second research interviews had the largest disparity in duration. Whereas the first interview had lasted two hours, the second interview lasted only one hour. I met with participant 1 at her home at the end of her working day and she let me know that she did not have any particular constraints on her time to limit the duration of the interview. In contrast, I met with participant 2 at her work during the day and we agreed to ensure the interview lasted only an hour as she had a meeting afterwards. These practical details were certainly significant in the disparity between the duration of the two interviews. However, I wondered whether differences in the content discussed and rapport developed during the interviews may have also been influential in the disparity if there had not been time constraints for participant 2.

I noticed differences in the content of the two interviews. Whereas participant 1 openly discussed her emotional experiences of therapeutic work with unaccompanied children, participant 2 was passionate about service issues impacting on therapeutic work. The interview mainly focused on her approach to therapeutic work with unaccompanied children themselves and also indirect interventions with colleagues, team members, other professionals and at a higher level in the borough in which she worked. Differences in the content of the interviews perhaps reflected the participants' different roles in their work. Part of the work participant 2 discussed indicated managerial roles and more strategic involvement in the development of mental health services for unaccompanied children.

I was also aware that participant 2 and I developed a qualitatively different rapport to the interview with participant 1. Participant 2 engaged less in discussion of emotions, meaning there was less of need for therapeutic responses. During the interview I noticed that this meant I was therefore more able to focus on information gathering and deciding follow-up questions to further explore issues. The participant

discussed issues beyond the questions I had originally developed for the semi-structured interview schedule; including the impact of restrictions on services on therapeutic work with unaccompanied children. The semi-structured interviewing approach allowed flexibility to follow the participant's lead and further explore this issue. Service-level issues were then added into the interview schedule for the second and third wave of data collection.

When asking questions to follow-up on issues, I was mindful of ensuring I framed these in ways that were open and was wary of closed or leading questions that risked putting words into participants' mouths. Constructing open questions is a skill important in therapeutic work, which I drew on during the research interviews. My awareness of ensuring questions were framed in an open way heightened my appreciation of the social constructionist view of data as co-constructed between researchers and participants. I was also conscious of reflecting on my influence on the construction of data during the interviews to privilege and prioritise participants' narratives over my own assumptions.

Reflections following initial coding of the first wave of interviewing, August 2011

When analysing the first wave of interviews, I was aware that I had no previous experience of coding qualitative data. Although I found Charmaz's (2006) recommendations for initial coding helpful, I was unsure whether I was coding the data in the 'correct' way. I wondered whether I had stayed too close to the data and had used participants' words as in-vivo codes too much. On the other hand, I also wondered whether I had not summarised the data sufficiently or made the codes concise enough. This connected to a challenge throughout the research process of finding a balance between describing and conceptualising the data. Coding the first interview was the most challenging. As the research progressed, the coding process became more familiar and I learned from my experiences of coding previous interview transcripts.

Reflections after the second wave of data collection, November 2011

During the recruitment process, I felt I had been lucky in being able to recruit the first seven participants with relative ease. However, after the second wave of data collection my recruitment felt as if it had ground to a halt. There had been many therapists interested in the study who I had emailed, but they had not responded or it had been difficult to arrange dates and times to meet due to their busy schedules. I found myself experiencing a dilemma of needing to recruit more participants to meet my aim of interviewing 8-12 therapists, but also being ethically aware of ensuring participation was voluntary. I therefore decided not to continue contact with therapists who were experiencing difficulties arranging meeting with me, as I did not want to pressure them to participate. This dilemma and the sudden change in pace of my recruitment highlighted for me the unpredictable nature of the research process; as well as the 'ups' and 'downs' of sometimes feeling as if I was making progress in contrast to other times when I felt somewhat 'stuck'. When emailing potential participants I had specified my availability, in terms of the dates and times I was available to meet for the research interview. Fortunately, two therapists responded belatedly to my initial email and we were able to arrange interviews. This meant I was able to complete my data collection and move onto focusing completely on data analysis and the construction of the grounded theory.

Reflections during data analysis, February 2012

After transcribing and coding my final interview, I felt overwhelmed by the amount of data I had collected. Although I had decided to develop a third interim analysis before generating the final analysis, the feeling of being overwhelmed by the size of the data was paralysing for several days as it created a sense of not knowing where to begin. Focused coding provided a helpful step between line-by-line initial coding and developing categories. I appreciated the structure of the grounded theory approach and it seemed to break the data analysis process down into more manageable steps. There was a sense of moving gradually from small segments of data in each transcript, to larger chunks of data interpreted as similar across transcripts.

As my data analysis progressed towards the construction of categories, I struggled with the interconnectedness of the data. It felt difficult to fully distinguish different categories and present them in a linear order, because participants' narratives seemed to move back and forth between each one. I used the idea of a timeline to try to organise processes in the data according to progression in therapeutic work, for example according to the two 'stages'; however it was apparent that the two stages themselves were not linear – that participants' accounts moved between the two. Constructing a way of presenting the analysis that fitted with the interconnectedness of the categories and circular movements between categories was a considerable challenge. Rather than presenting fragmented categories, interweaving concepts throughout the analysis was also felt to be useful to create a sense of interconnectedness between the categories.

Reflections before completing the thesis, April 2012

Time constraints on the research and word limits on the presentation of the output of the analysis meant that I was aware the present study had not discussed all of the issues raised in the data. For example, two participants had given accounts of talking to unaccompanied children when they had been taken into detention centres. I felt that some of the qualities of the experiences participants described were represented in the analysis in relation to feelings of anger, frustration and injustice towards the UK asylum system. However, these examples also highlighted to me the limits of issues that can be covered in one report. I had previously wondered why Charmaz had returned to the same participants and data to produce multiple analyses (e.g. 1983, 1987, 1990, 1991). My experience of the present research has helped me to understand the numerous possibilities held within data and why researchers might therefore return to data to construct multiple analyses. I am aware that at present I am in the early stages of my journey as a clinical psychologist. Alessandra Lemma is an incredibly experienced clinician, when I read Lemma's (2010) grounded theory of key-workers relationships with children at Kids Company, I also wondered what my analysis of the data in my present research would look like in years to come, once I have more experience and am perhaps more sensitised to issues that arise in therapeutic work.